I: State Information

State Information

Plan Year

Start Year:
2012

End Year:
2014

State DUNS Number

Number
802743534

Extension

I. State Agency to be the Grantee for the Block Grant

Agency Name
North Dakota Department of Human Services

Organizational Unit
Division of Mental Health and Substance Abuse Services

Mailing Address
1237 West Divide Avenue, Suite 1C

City
Bismarck

Zip Code
58501

II. Contact Person for the Grantee of the Block Grant

First Name
JoAnne

Last Name
Hoesel

Agency Name
North Dakota Department of Human Services

Mailing Address
1237 West Divide Avenue, Suite 1C

City
Bismarck

Zip Code
58501

Telephone
701-328-8924

Fax
701-328-8969

Email Address
jhoesel@nd.gov

III. State Expenditure Period (Most recent State expenditure period that is closed out)

From
7/1/2010

To
6/30/2011

IV. Date Submitted

NOTE: this field will be automatically populated when the application is submitted.

Submission Date

Revision Date

V. Contact Person Responsible for Application Submission

First Name

JoAnne

Last Name

Hoesel

Telephone

701-328-8924

Fax

701-328-8969

Email Address

jhoesel@nd.gov

Footnotes:

I: State Information

Assurances - Non-Construction Programs

Public reporting burden for this collection of information is estimated to average 15 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the Office of Management and Budget, Paperwork Reduction Project (0348-0040), Washington, DC 20503.

PLEASE DO NOT RETURN YOUR COMPLETED FORM TO THE OFFICE OF MANAGEMENT AND BUDGET. SEND IT TO THE ADDRESS PROVIDED BY THE SPONSORING AGENCY.

Note: Certain of these assurances may not be applicable to your project or program. If you have questions, please contact the awarding agency. Further, certain Federal awarding agencies may require applicants to certify to additional assurances. If such is the case, you will be notified.

As the duly authorized representative of the applicant I certify that the applicant:

1. Has the legal authority to apply for Federal assistance, and the institutional, managerial and financial capability (including funds sufficient to pay the non-Federal share of project costs) to ensure proper planning, management and completion of the project described in this application.
2. Will give the awarding agency, the Comptroller General of the United States, and if appropriate, the State, through any authorized representative, access to and the right to examine all records, books, papers, or documents related to the award; and will establish a proper accounting system in accordance with generally accepted accounting standard or agency directives.
3. Will establish safeguards to prohibit employees from using their positions for a purpose that constitutes or presents the appearance of personal or organizational conflict of interest, or personal gain.
4. Will initiate and complete the work within the applicable time frame after receipt of approval of the awarding agency.
5. Will comply with the Intergovernmental Personnel Act of 1970 (42 U.S.C. §§4728-4763) relating to prescribed standards for merit systems for programs funded under one of the nineteen statutes or regulations specified in Appendix A of OPM's Standard for a Merit System of Personnel Administration (5 C.F.R. 900, Subpart F).
6. Will comply with all Federal statutes relating to nondiscrimination. These include but are not limited to: (a) Title VI of the Civil Rights Act of 1964 (P.L. 88-352) which prohibits discrimination on the basis of race, color or national origin; (b) Title IX of the Education Amendments of 1972, as amended (20 U.S.C. §§1681-1683, and 1685-1686), which prohibits discrimination on the basis of sex; (c) Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. §§794), which prohibits discrimination on the basis of handicaps; (d) the Age Discrimination Act of 1975, as amended (42 U.S.C. §§6101-6107), which prohibits discrimination on the basis of age; (e) the Drug Abuse Office and Treatment Act of 1972 (P.L. 92-255), as amended, relating to nondiscrimination on the basis of drug abuse; (f) the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970 (P.L. 91-616), as amended, relating to nondiscrimination on the basis of alcohol abuse or alcoholism; (g) §§523 and 527 of the Public Health Service Act of 1912 (42 U.S.C. §§290 dd-3 and 290 ee-3), as amended, relating to confidentiality of alcohol and drug abuse patient records; (h) Title VIII of the Civil Rights Act of 1968 (42 U.S.C. §§3601 et seq.), as amended, relating to non-discrimination in the sale, rental or financing of housing; (i) any other nondiscrimination provisions in the specific statute(s) under which application for Federal assistance is being made; and (j) the requirements of any other nondiscrimination statute(s) which may apply to the application.
7. Will comply, or has already complied, with the requirements of Title II and III of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 (P.L. 91-646) which provide for fair and equitable treatment of persons displaced or whose property is acquired as a result of Federal or federally assisted programs. These requirements apply to all interests in real property acquired for project purposes regardless of Federal participation in purchases.
8. Will comply with the provisions of the Hatch Act (5 U.S.C. §§1501-1508 and 7324-7328) which limit the political activities of employees whose principal employment activities are funded in whole or in part with Federal funds.
9. Will comply, as applicable, with the provisions of the Davis-Bacon Act (40 U.S.C. §§276a to 276a-7), the Copeland Act (40 U.S.C. §276c and 18 U.S.C. §874), and the Contract Work Hours and Safety Standards Act (40 U.S.C. §§327-333), regarding labor standards for federally assisted construction subagreements.
10. Will comply, if applicable, with flood insurance purchase requirements of Section 102(a) of the Flood Disaster Protection Act of 1973 (P.L. 93-234) which requires recipients in a special flood hazard area to participate in the program and to purchase flood insurance if the total cost of insurable construction and acquisition is $10,000 or more.
11. Will comply with environmental standards which may be prescribed pursuant to the following: (a) institution of environmental quality control measures under the National Environmental Policy Act of 1969 (P.L. 91-190) and Executive Order (EO) 11514; (b) notification of violating facilities pursuant to EO 11738; (c) protection of wetland pursuant to EO 11990; (d) evaluation of flood hazards in floodplains in accordance with EO 11988; (e) assurance of project consistency with the approved State management program developed under the Costal Zone Management Act of 1972 (16 U.S.C. §§1451 et seq.); (f) conformity of Federal actions to State (Clear Air) Implementation Plans under Section 176(c) of the Clear Air Act of 1955, as amended (42 U.S.C. §§7401 et seq.); (g) protection of underground sources of drinking water under the Safe Drinking Water Act of 1974, as amended, (P.L. 93-523); and (h) protection of endangered species under the Endangered Species Act of 1973, as amended, (P.L. 93-205).
12. Will comply with the Wild and Scenic Rivers Act of 1968 (16 U.S.C. §§1271 et seq.) related to protecting components or potential components of the national wild and scenic rivers system.
13. Will assist the awarding agency in assuring compliance with Section 106 of the National Historic Preservation Act of 1966, as amended (16 U.S.C. §470), EO 11593 (identification and protection of historic properties), and the Archaeological and Historic Preservation Act of 1974 (16 U.S.C. §§469a-1 et seq.).

14. Will comply with P.L. 93-348 regarding the protection of human subjects involved in research, development, and related activities supported by this award of assistance.
15. Will comply with the Laboratory Animal Welfare Act of 1966 (P.L. 89-544, as amended, 7 U.S.C. §§2131 et seq.) pertaining to the care, handling, and treatment of warm blooded animals held for research, teaching, or other activities supported by this award of assistance.
16. Will comply with the Lead-Based Paint Poisoning Prevention Act (42 U.S.C. §§4801 et seq.) which prohibits the use of lead based paint in construction or rehabilitation of residence structures.
17. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act of 1984.
18. Will comply with all applicable requirements of all other Federal laws, executive orders, regulations and policies governing this program.

Name	Carol K. Olson
Title	Executive Director
Organization	North Dakota Department of Human Services

Signature: _____ Date: _____

Footnotes:

I: State Information

Certifications

1. Certification Regarding Debarment and Suspension

The undersigned (authorized official signing for the applicant organization) certifies to the best of his or her knowledge and belief, that the applicant, defined as the primary participant in accordance with 45 CFR Part 76, and its principals:

a. are not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from covered transactions by any Federal Department or agency;
b. have not within a 3-year period preceding this proposal been convicted of or had a civil judgment rendered against them for commission of fraud or a criminal offense in connection with obtaining, attempting to obtain, or performing a public (Federal, State, or local) transaction or contract under a public transaction; violation of Federal or State antitrust statutes or commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements, or receiving stolen property;
c. are not presently indicted or otherwise criminally or civilly charged by a governmental entity (Federal, State, or local) with commission of any of the offenses enumerated in paragraph (b) of this certification; and
d. have not within a 3-year period preceding this application/proposal had one or more public transactions (Federal, State, or local) terminated for cause or default.

Should the applicant not be able to provide this certification, an explanation as to why should be placed after the assurances page in the application package.

The applicant agrees by submitting this proposal that it will include, without modification, the clause titled "Certification Regarding Debarment, Suspension, Ineligibility, and Voluntary Exclusion--Lower Tier Covered Transactions" in all lower tier covered transactions (i.e., transactions with subgrantees and/or contractors) and in all solicitations for lower tier covered transactions in accordance with 45 CFR Part 76.

2. Certification Regarding Drug-Free Workplace Requirements

The undersigned (authorized official signing for the applicant organization) certifies that the applicant will, or will continue to, provide a drug -free work-place in accordance with 45 CFR Part 76 by:

a. Publishing a statement notifying employees that the unlawful manufacture, distribution, dispensing, possession or use of a controlled substance is prohibited in the grantee's work-place and specifying the actions that will be taken against employees for violation of such prohibition;
b. Establishing an ongoing drug-free awareness program to inform employees about--
    1. The dangers of drug abuse in the workplace;
    2. The grantee's policy of maintaining a drug-free workplace;
    3. Any available drug counseling, rehabilitation, and employee assistance programs; and
    4. The penalties that may be imposed upon employees for drug abuse violations occurring in the workplace;
c. Making it a requirement that each employee to be engaged in the performance of the grant be given a copy of the statement required by paragraph (a) above;
d. Notifying the employee in the statement required by paragraph (a), above, that, as a condition of employment under the grant, the employee will--
    1. Abide by the terms of the statement; and
    2. Notify the employer in writing of his or her conviction for a violation of a criminal drug statute occurring in the workplace no later than five calendar days after such conviction;
e. Notifying the agency in writing within ten calendar days after receiving notice under paragraph (d)(2) from an employee or otherwise receiving actual notice of such conviction. Employers of convicted employees must provide notice, including position title, to every grant officer or other designee on whose grant activity the convicted employee was working, unless the Federal agency has designated a central point for the receipt of such notices. Notice shall include the identification number(s) of each affected grant;
f. Taking one of the following actions, within 30 calendar days of receiving notice under paragraph (d) (2), with respect to any employee who is so convicted?
    1. Taking appropriate personnel action against such an employee, up to and including termination, consistent with the requirements of the Rehabilitation Act of 1973, as amended; or
    2. Requiring such employee to participate satisfactorily in a drug abuse assistance or rehabilitation program approved for such purposes by a Federal, State, or local health, law enforcement, or other appropriate agency;
g. Making a good faith effort to continue to maintain a drug-free workplace through implementation of paragraphs (a), (b), ?, (d), ?, and (f).

For purposes of paragraph ? regarding agency notification of criminal drug convictions, the DHHS has designated the following central point for receipt of such notices:

Office of Grants and Acquisition Management
Office of Grants Management
Office of the Assistant Secretary for Management and Budget

Department of Health and Human Services
200 Independence Avenue, S.W., Room 517-D
Washington, D.C. 20201

3. Certifications Regarding Lobbying

Title 31, United States Code, Section 1352, entitled "Limitation on use of appropriated funds to influence certain Federal contracting and financial transactions," generally prohibits recipients of Federal grants and cooperative agreements from using Federal (appropriated) funds for lobbying the Executive or Legislative Branches of the Federal Government in connection with a SPECIFIC grant or cooperative agreement. Section 1352 also requires that each person who requests or receives a Federal grant or cooperative agreement must disclose lobbying undertaken with non-Federal (non-appropriated) funds. These requirements apply to grants and cooperative agreements EXCEEDING $100,000 in total costs (45 CFR Part 93).

The undersigned (authorized official signing for the applicant organization) certifies, to the best of his or her knowledge and belief, that:

1. No Federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement.
2. If any funds other than Federally appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form-LLL, "Disclosure of Lobbying Activities," in accordance with its instructions. (If needed, Standard Form-LLL, "Disclosure of Lobbying Activities," its instructions, and continuation sheet are included at the end of this application form.)
3. The undersigned shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontracts, subgrants, and contracts under grants, loans and cooperative agreements) and that all subrecipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by Section 1352, U.S. Code. Any person who fails to file the required certification shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

4. Certification Regarding Program Fraud Civil Remedies Act (PFCRA)

The undersigned (authorized official signing for the applicant organization) certifies that the statements herein are true, complete, and accurate to the best of his or her knowledge, and that he or she is aware that any false, fictitious, or fraudulent statements or claims may subject him or her to criminal, civil, or administrative penalties. The undersigned agrees that the applicant organization will comply with the Public Health Service terms and conditions of award if a grant is awarded as a result of this application.

5. Certification Regarding Environmental Tobacco Smoke

Public Law 103-227, also known as the Pro-Children Act of 1994 (Act), requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted for by an entity and used routinely or regularly for the provision of health, daycare, early childhood development services, education or library services to children under the age of 18, if the services are funded by Federal programs either directly or through State or local governments, by Federal grant, contract, loan, or loan guarantee. The law also applies to children's services that are provided in indoor facilities that are constructed, operated, or maintained with such Federal funds. The law does not apply to children's services provided in private residence, portions of facilities used for inpatient drug or alcohol treatment, service providers whose sole source of applicable Federal funds is Medicare or Medicaid, or facilities where WIC coupons are redeemed.

Failure to comply with the provisions of the law may result in the imposition of a civil monetary penalty of up to $1,000 for each violation and/or the imposition of an administrative compliance order on the responsible entity.

By signing the certification, the undersigned certifies that the applicant organization will comply with the requirements of the Act and will not allow smoking within any portion of any indoor facility used for the provision of services for children as defined by the Act.

The applicant organization agrees that it will require that the language of this certification be included in any subawards which contain provisions for children's services and that all subrecipients shall certify accordingly.

The Public Health Services strongly encourages all grant recipients to provide a smoke-free workplace and promote the non-use of tobacco products. This is consistent with the PHS mission to protect and advance the physical and mental health of the American people.

Name	Carol K. Olson
Title	Executive Director
Organization	North Dakota Department of Human Services

Signature: _____ Date: _____

Footnotes:

I: State Information

Chief Executive Officer's Funding Agreements/Certifications (Form 3) [SAPT]

FY 2012 Substance Abuse Prevention and Treatment Block Grant Funding Agreements/Certifications as required by Title XIX, Part B, Subpart II and Subpart III of the Public Health Service (PHS) Act

Title XIX, Part B, Subpart II and Subpart III of the PHS Act, as amended, requires the chief executive officer (or an authorized designee) of the applicant organization to certify that the State will comply with the following specific citations as summarized and set forth below, and with any regulations or guidelines issued in conjunction with this Subpart except as exempt by statute.

SAMHSA will accept a signature on this form as certification of agreement to comply with the cited provisions of the PHS Act. If signed by a designee, a copy of the designation must be attached.

I. FORMULA GRANTS TO STATES, SECTION 1921

II. Certain Allocations (Prevention Programs utilizing IOM populations ; Pregnant women and women with dependent children) Section 1922

III. INTRAVENOUS DRUG ABUSE, SECTION 1923

IV. REQUIREMENTS REGARDING TUBERCULOSIS AND HUMAN IMMUNODEFICIENCY VIRUS, SECTION 1924

V. Group Homes for Recovering Substance Abusers, Section 1925

VI. State Law Regarding Sale of Tobacco Products to Individuals Under Age of 18, Section 1926

VII. TREATMENT SERVICES FOR PREGNANT WOMEN, SECTION 1927

VIII. ADDITIONAL AGREEMENTS(IMPROVED REFERRAL PROCESS, CONTINUING EDUCATION, COORDINATION OF ACTIVITIES AND SERVICES), SECTION 1928

IX. IX SUBMISSION TO SECRETARY OF STATEWIDE ASSESSMENT OF NEEDS, SECTION 1929

X. MAINTENANCE OF EFFORT REGARDING STATE EXPENDITURES, SECTION 1930

XI. Restrictions on Expenditure of Grant, Section 1931

XII. APPLICATION FOR GRANT; APPROVAL OF STATE PLAN, SECTION 1932

XIII. Opportunity for Public Comment on State Plans, Section 1941

XIV. Requirement of Reports and Audits by States, Section 1942

XV. ADDITIONAL REQUIREMENTS, SECTION 1943

XVI. Prohibitions Regarding Receipt of Funds, Section 1946

XVII. Nondiscrimination, Section 1947

XVIII. Continuation of Certain Programs, Section 1953

XIX. Services Provided By Nongovernmental Organizations, Section 1955

XX. Services for Individuals with Co-Occurring Disorders, Section 1956

I hereby certify that North Dakota will comply with Title XIX, Part B, Subpart II and Subpart III of the Public Health Service (PHS) Act, as amended, as summarized above, except for those sections in the PHS Act that do not apply or for which a waiver has been granted or may be granted by the Secretary for the period covered by this agreement.

Name	Jack Dalrymple
Title	Governor
Organization	State of North Dakota

Signature: _____ Date: _____

Footnotes:

I: State Information

Chief Executive Officer's Funding Agreements/Certifications (Form 3) [CMHS]

Community Mental Health Services Block Grant Funding Agreements
FISCAL YEAR 2012

I hereby certify that North Dakota agrees to comply with the following sections of Title V of the Public Health Service Act [42 U.S.C. 300x-1 et seq.]

I. Section 1911:

Subject to Section 1916, the State will expend the grant only for the purpose of:
i. Carrying out the plan under Section 1912(a) [State Plan for Comprehensive Community Mental Health Services] by the State for the fiscal year involved:
ii. Evaluating programs and services carried out under the plan; and
iii. Planning, administration, and educational activities related to providing services under the plan.

II. Section 1912:

(c)(1)&(2) [As a funding agreement for a grant under Section 1911 of this title] The Secretary establishes and disseminates definitions for the terms “adults with a serious mental illness” and “children with a severe emotional disturbance” and the States will utilize such methods [standardized methods, established by the Secretary] in making estimates [of the incidence and prevalence in the State of serious mental illness among adults and serious emotional disturbance among children].

III. Section 1913:

(a)(1)(C) In the case for a grant for fiscal year 2011, the State will expend for such system [of integrated services described in section 1912(b)(3)] not less than an amount equal to the amount expended by the State for the fiscal year 1994.

[A system of integrated social services, educational services, juvenile services and substance abuse services that, together with health and mental health services, will be provided in order for such children to receive care appropriate for their multiple needs (which includes services provided under the Individuals with Disabilities Education Act)].

(b)(1) The State will provide services under the plan only through appropriate, qualified community programs (which may include community mental health centers, child mental-health programs, psychosocial rehabilitation programs, mental health peer-support programs, and mental-health primary consumer-directed programs).

(b)(2) The State agrees that services under the plan will be provided through community mental health centers only if the centers meet the criteria specified in subsection (c).

(C)(1) With respect to mental health services, the centers provide services as follows:

(A) Services principally to individuals residing in a defined geographic area (referred to as a “service area”)
(B) Outpatient services, including specialized outpatient services for children, the elderly, individuals with a serious mental illness, and residents of the service areas of the centers who have been discharged from inpatient treatment at a mental health facility.
(C) 24-hour-a-day emergency care services.
(D) Day treatment or other partial hospitalization services, or psychosocial rehabilitation services.
(E) Screening for patients being considered for admissions to State mental health facilities to determine the appropriateness of such admission.

(2) The mental health services of the centers are provided, within the limits of the capacities of the centers, to any individual residing or employed in the service area of the center regardless of ability to pay for such services.

(3) The mental health services of the centers are available and accessible promptly, as appropriate and in a manner which preserves human dignity and assures continuity and high quality care.

IV. Section 1914:

The State will establish and maintain a State mental health planning council in accordance with the conditions described in this section.

(b) The duties of the Council are:
(1) to review plans provided to the Council pursuant to section 1915(a) by the State involved and to submit to the State any recommendations of the Council for modifications to the plans;
(2) to serve as an advocate for adults with a serious mental illness, children with a severe emotional disturbance, and other individuals with mental illness or emotional problems; and
(3) to monitor, review, and evaluate, not less than once each year, the allocation and adequacy of mental health services within the State.

(c)(1) A condition under subsection (a) for a Council is that the Council is to be composed of residents of the State, including representatives of:

(A) the principle State agencies with respect to:
(i) mental health, education, vocational rehabilitation, criminal justice, housing, and social services; and
(ii) the development of the plan submitted pursuant to Title XIX of the Social Security Act;
(B) public and private entities concerned with the need, planning, operation, funding, and use of mental health services and related support services;
(C) adults with serious mental illnesses who are receiving (or have received) mental health services; and
(D) the families of such adults or families of children with emotional disturbance.

(2) A condition under subsection (a) for a Council is that:
(A) with respect to the membership of the Council, the ratio of parents of children with a serious emotional disturbance to other members of the Council is sufficient to provide adequate representation of such children in the deliberations of the Council; and
(B) not less than 50 percent of the members of the Council are individuals who are not State employees or providers of mental health services.

V. Section 1915:

(a)(1) State will make available to the State mental health planning council for its review under section 1914 the State plan submitted under section 1912(a) with respect to the grant and the report of the State under section 1942(a) concerning the preceding fiscal year.
(2) The State will submit to the Secretary any recommendations received by the State from the Council for modifications to the State plan submitted under section 1912(a) (without regard to whether the State has made the recommended modifications) and comments on the State plan implementation report on the preceding fiscal year under section 1942(a).

(b)(1) The State will maintain State expenditures for community mental health services at a level that is not less than the average level of such expenditures maintained by the State for the 2-year period preceding the fiscal year for which the State is applying for the grant.

VI. Section 1916:

(a) The State agrees that it will not expend the grant:

(1) to provide inpatient services;
(2) to make cash payments to intended recipients of health services;
(3) to purchase or improve land, purchase, construct, or permanently improve (other than minor remodeling) any building or other facility, or purchase major medical equipment;
(4) to satisfy any requirement for the expenditure of non-Federal funds as a condition of the receipt of Federal funds; or
(5) to provide financial assistance to any entity other than a public or nonprofit entity.

(b) The State agrees to expend not more than 5 percent of the grant for administrative expenses with respect to the grant.

VII. Section 1941:

The State will make the plan required in section 1912 as well as the State plan implementation report for the preceding fiscal year required under Section 1942(a) public within the State in such manner as to facilitate comment from any person (including any Federal or other public agency) during the development of the plan (including any revisions) and after the submission of the plan to the Secretary.

VIII. Section 1942:

(a) The State agrees that it will submit to the Secretary a report in such form and containing such information as the Secretary determines (after consultation with the States) to be necessary for securing a record and description of:

(1) the purposes for which the grant received by the State for the preceding fiscal year under the program involved were expended and a description of the activities of the State under the program; and
(2) the recipients of amounts provided in the grant.

(b) The State will, with respect to the grant, comply with Chapter 75 of Title 31, United Stated Code. [Audit Provision]
(c) The State will:
(1) make copies of the reports and audits described in this section available for public inspection within the State; and
(2) provide copies of the report under subsection (a), upon request, to any interested person (including any public agency).

IX. Section 1943:

(1)(A) for the fiscal year for which the grant involved is provided, provide for independent peer review to assess the quality, appropriateness, and efficacy of treatment services provided in the State to individuals under the program involved; and
(B) ensure that, in the conduct of such peer review, not fewer than 5 percent of the entities providing services in the State under such program are reviewed (which 5 percent is representative of the total population of such entities);
(2) permit and cooperate with Federal investigations undertaken in accordance with section 1945 [Failure to Comply with Agreements]; and
(3) provide to the Secretary any data required by the Secretary pursuant to section 505 and will cooperate with the Secretary in the development of uniform criteria for the collection of data pursuant to such section

(b) The State has in effect a system to protect from inappropriate disclosure patient records maintained by the State in connection with an activity funded under the program involved or by any entity, which is receiving amounts from the grant.

Notice: Should the President's FY 2008 Budget be enacted, the following statement applies only to States that received the Mental Health Transformation State Infrastructure Grants:

This Agreement certifies that States that received the Mental Health Transformation State Infrastructure Grants shall not use FY 2008 Mental Health Block Grant transformation funding to supplant activities funded by the Mental Health Transformation Infrastructure Grants.

Name	Jack Dalrymple
Title	Governor
Organization	State of North Dakota

Signature: _____ Date: _____

Footnotes:

I: State Information

Disclosure of Lobbying Activities (SF-LLL)

To View Standard Form LLL, Click the link below (This form is OPTIONAL)

Standard Form LLL (click here)

Footnotes:

II: Planning Steps

Step 1: Assess the strengths and needs of the service system to address the specific populations

Page 22 of the Application Guidance

Narrative Question:

Provide an overview of the State's behavioral health prevention, early identification, treatment, and recovery support systems. Describe how the public behavioral health system is currently organized at the State, intermediate and local levels differentiating between child and adult systems. This description should include a discussion of the roles of the SSA, the SMHA and other State agencies with respect to the delivery of behavioral health services. States should also include a description of regional, county, and local entities that provide behavioral health services or contribute resources that assist in providing the services. The description should also include how these systems address the needs of diverse racial, ethnic and sexual gender minorities as well as youth who are often underserved.

Footnotes:

GENERAL DEMOGRAPHICS

North Dakota is a rural, frontier state with an area of 72,000 square miles and a population of 672,591. The largest city in the state is Fargo, which has a population of 105,549 persons. The majority of North Dakotans (53 percent) reside in the top four populated counties (Cass, Burleigh, Grand Forks, and Ward). The Red River Valley area along the North Dakota-Minnesota border encompasses roughly one-third of the State. In fact, nearly two thirds of the State's population resides in this narrow corridor. In comparison, the western half of the State has a population density from 0.9 to 10.7 persons per square mile. Thirty-six of fifty-three counties are designated frontier areas, having less than seven persons per square mile. Vast distances between towns, farmsteads, and services require residents to spend many hours in travel.

In 1982, to better serve the citizens of this rural state, the community mental health centers were merged with the area social service centers. This action created the regional human service centers and developed a one-stop system of care.

THE DEPARTMENT OF HUMAN SERVICES

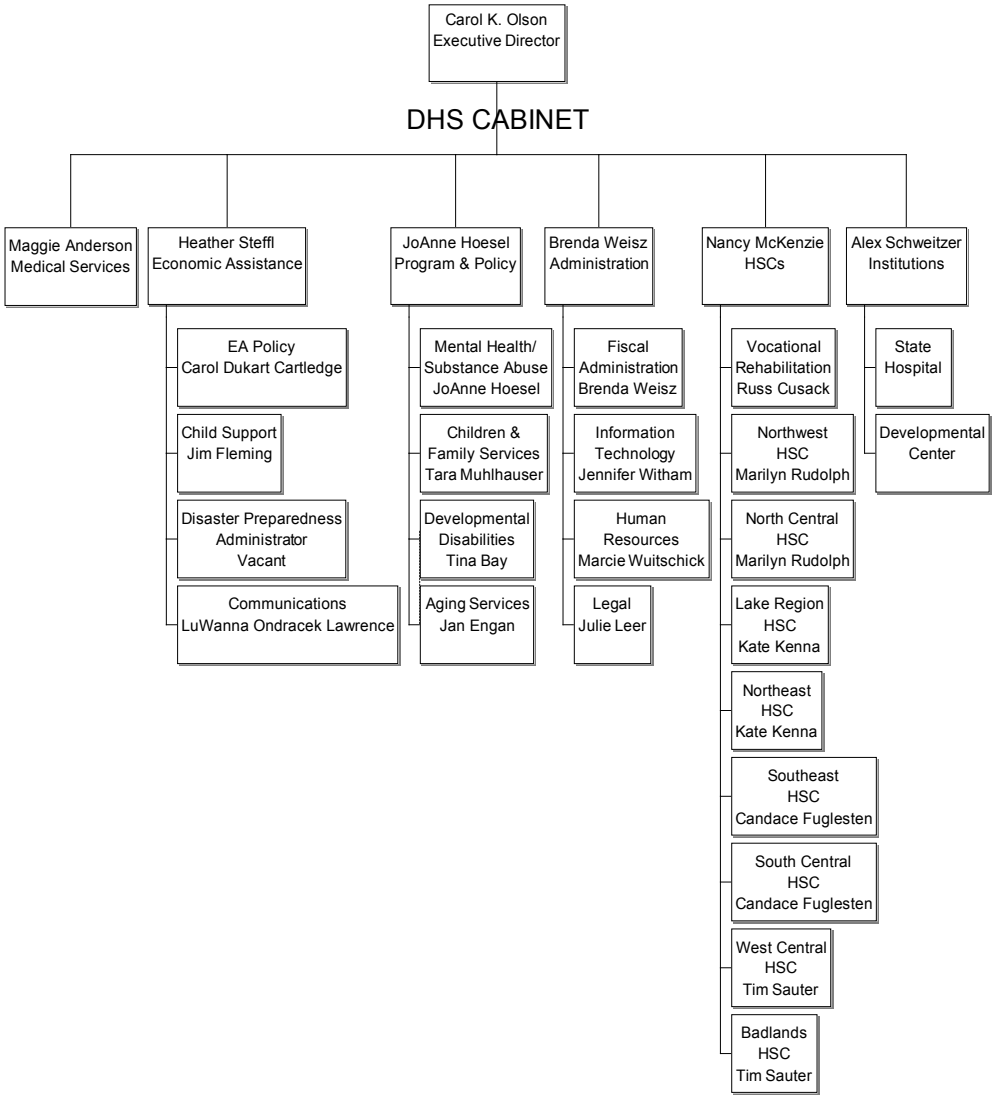
The Department of Human Services is the State governmental administrative agency that provides services that help vulnerable North Dakotans of all ages to maintain or enhance their quality of life, which may be threatened by lack of financial resources, emotional crises, disabling conditions, or an inability to protect themselves. The Department administers comprehensive human services and economic assistance on behalf of individuals and families in North Dakota. It is an umbrella agency headed by an executive director appointed by the Governor. Comprised of over 2,000 employees, the Department of Human Services has six major organizational components overseen by the DHS Cabinet:

- Medical Services: Coordinates policy and operations of the Medicaid program in North Dakota.
- Economic Assistance: Directs policy for economic assistance programs and oversees policy and operations for Child Support Enforcement.
- Program and Policy: Coordinates administrative programs for the elderly, children and families, substance abuse, disability services, and mental health.
- Human Service Centers: Administers, supervises, and provides a wide range of public human services through the eight regional human service centers
- Institutions: Coordinates administration of the North Dakota State Hospital and the Developmental Center.
- Fiscal: Oversees all fiscal administrative functions for the Department.

Delivering human services involves a partnership between the Department, counties, tribes, and service providers. For instance, a number of human service centers contract with private non-profit providers for crisis residential services as well as the Recovery Centers. The Department receives and distributes funds furnished by the North Dakota Legislature and Congress. Funds may be sent directly to providers or to people whom the counties determine

qualify for programs and benefits. The Department provides direction and technical assistance, sets standards, conducts training, and manages the computerized eligibility system.

The Division of Mental Health and Substance Abuse Services is a part of the Program and Policy component of the Department of Human Services. Its specific functions are detailed later in the application. The Division functions as the State Mental Health Authority. It works closely with other public agencies (such as the Department of Public Instruction, the Department of Health, and the Department of Corrections and Rehabilitation) as well as a myriad of private and not-for-profit human service agencies to ensure quality and effective mental health services are provided throughout the state.

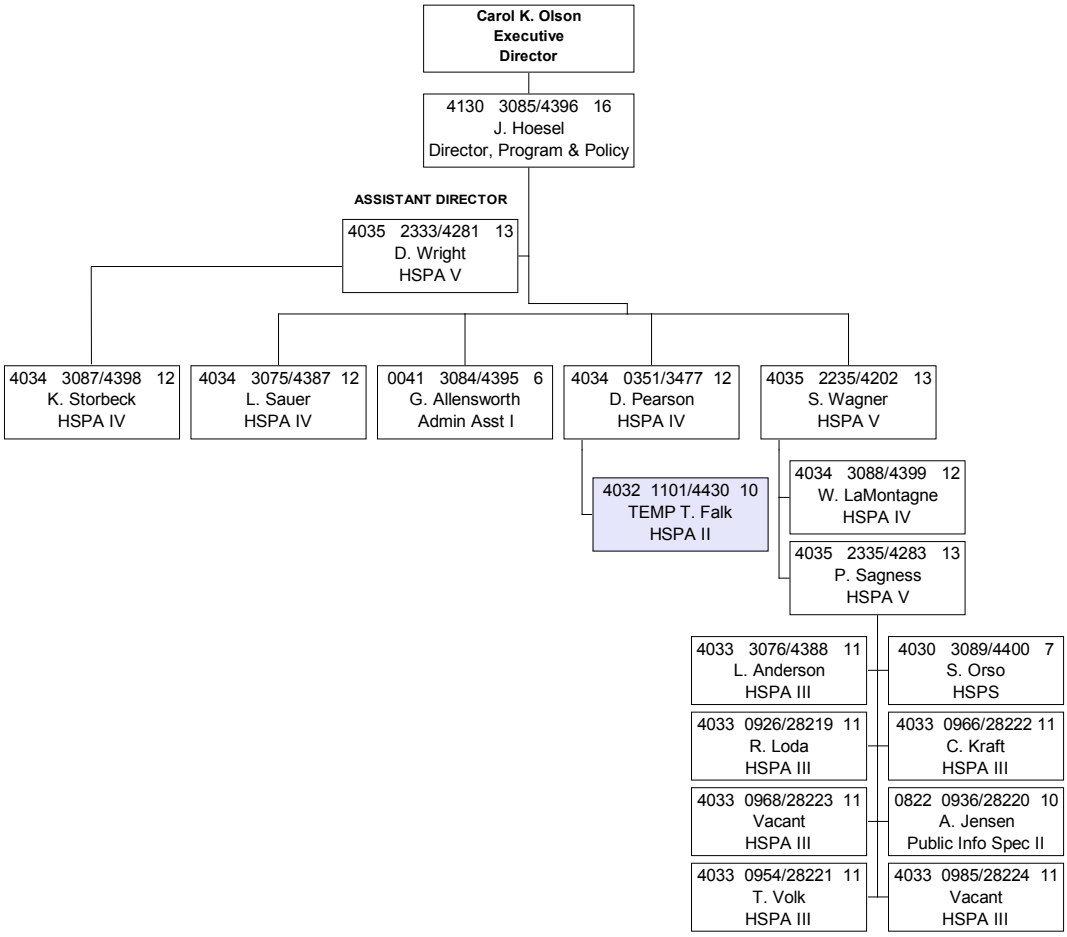


THE DIVISION OF MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES

The Division of Mental Health and Substance Abuse Services – a part of Program and Policy – provides leadership to the field in developing systems and models of care for mental illness and substance abuse, including dual diagnosis (mental health/substance abuse). It is charged with licensing alcohol and drug abuse treatment programs as well as psychiatric residential treatment facilities for youth with serious emotional disorders. In addition, the Division seeks active involvement in a variety of interagency and multi-organization efforts designed to advance understanding of mental health and substance abuse issues.

The Division (Figure 1) performs leadership, planning, development, and implementation functions in the field of behavioral health for the State of North Dakota.

Figure 1. Division of Mental Health and Substance Abuse Services



These include:

- Planning and Research: A vital component to a solid mental health system and planning process is research. In an effort to improve the availability and use of data by managers and division directors within the Department of Human Services in decision-making and

planning efforts, the Department has implemented the Mental Health Statistical Improvement Program (MHSIP) Outcomes Project and Drug Abuse Services Information System (DASIS) statewide. Interfaced with the Partnership Program Outcome Measurement project and other community mental health data systems. MHSIP will allow the Mental Health Services Researcher to compile data leading to an overall enhanced planning and reporting process.

Using appropriate data gathered via the above-mentioned data systems and working closely with the regional human service centers, consumers and their families, private providers, and other stakeholders, the Division drafts and implements the annual State Plan on Mental Health.

- Grant Writing: The Division currently works with the following grants and actively seeks other funding opportunities via the Federal government grant programs:
  - The Combined Behavioral Health Assessment and Plan
  - State Data Infrastructure Grant
  - The Project for Assistance In Transition from Homelessness (PATH) Grant
  - Strategic Prevention Framework-State Incentive Grant (SPF-SIG)
  - Enforcing Underage Drinking Laws (EUDL)
  - The Immediate and Regular Services Grants of Crisis Counseling
  - Traumatic Brain Injury Grant through HRSA

- Policy Development and Implementation: The Division develops mental health programs and policies for the State of North Dakota. Implementation of these programs and policies is a function of the regional human service centers and the North Dakota State Hospital. The Division provides technical assistance and consultation concerning mental health programs and policies to the human service centers as well as any other agency, organization, and/or citizen of North Dakota. It also serves as a liaison between the Federal government, state/local entities, and the citizens of North Dakota.

- Licensing of Psychiatric Residential Treatment Facilities: These facilities provide children and adolescents a total, twenty-four hour, therapeutic environment integrating group living, educational services, and a clinical program based upon a comprehensive, interdisciplinary clinical assessment and an individualized treatment plan that meets the needs of the child and family. The facilities are: Dakota Boys and Girls Ranch – Fargo, Dakota Boys and Girls Ranch – Minot, Western Plains (DBGR) – Bismarck, Luther Hall – Fargo, Pride Manchester House – Bismarck, and Ruth Meiers Adolescent Center – Grand Forks. The Division provides regulatory oversight and provides a licensing survey process to ascertain if the facilities are meeting licensure standards. All North Dakota PRTF's continue to be in good standings with their accreditation body, allowing the Mental Health and Substance Abuse Services and Medical Services Divisions the ability to issue a deemed status license for the time period of July 1, 2011 to June 30, 2013.

- Licensing of Substance Abuse Treatment Programs: The division, through administrative rule, licenses:
  - Clinically Managed Low-Intensity Residential Care - Adult ASAM Level III.1,
  - Clinically Managed Low-Intensity Residential Care - Adolescent ASAM Level III.1,
  - Clinically Managed High-Intensity Residential Care - Adult ASAM Level III.5,
  - Clinically Managed Medium-Intensity Residential Care - Adolescent ASAM Level III.5,
  - Medically Monitored Intensive Inpatient Treatment - Adult ASAM Level III.7,
  - Medically Monitored High-Intensity Inpatient Treatment Adolescent ASAM Level III.7,

- Partial Hospitalization - Day Treatment - Adult ASAM Level II.5,
- Partial Hospitalization - Day Treatment - Adolescent ASAM Level II.5,
- Intensive Outpatient Treatment - Adult ASAM Level II.1,
- Intensive Outpatient Treatment - Adolescent ASAM Level II.1,
- Outpatient Services - Adult ASAM Level I,
- Outpatient Services - Adolescent ASAM Level I,
- Social Detoxification ASAM Level II.2-D, and
- the DUI Seminar ASAM Level 0.5 throughout the state.

On-site licensure visits to each provider are conducted every two years. There are currently in excess of 80 licensed providers in North Dakota.

- Licensing of the Regional Human Service Centers: The Division is the lead entity for the licensing of the eight regional human service centers. Using North Dakota Administrative Rule 75-05, the Division oversees a multidisciplinary team consisting of representatives from the Aging Services Division, Developmental Disabilities Division, Division of Vocational Rehabilitation, and the Children and Family Services Division. In addition, the Division contract for the services of a licensed psychologist, a registered nurse, a licensed addiction counselor, and a consumer or family member. The team conducts licensing on a biennial basis, four human service centers each year.

- Education: In addition to sponsoring training workshops and performing public speaking as requested, the Division contributes to the North Dakota Prevention Resource and Media Center. The Prevention Resource and Media Center (PRMC) focuses on technology, evidence-based prevention strategies, marketing, mass communication, and as a user friendly media resource center/clearinghouse for the citizens of North Dakota. The mission of the PRMC is to increase community awareness of substance abuse prevention and increase awareness of effective prevention strategies by providing innovative, quality, and culturally appropriate information to the residents of North Dakota. All PRMC materials are available through the State Library electronic system, accessed online, in person, by e-mail, or by phone. Materials are also available on mental health, traumatic brain injury, and suicide prevention.

SERVICES AT THE REGIONAL HUMAN SERVICE CENTERS

The eight regional human service centers, listed below with their locations, provide public behavioral health programs to service areas ranging from three to ten counties.

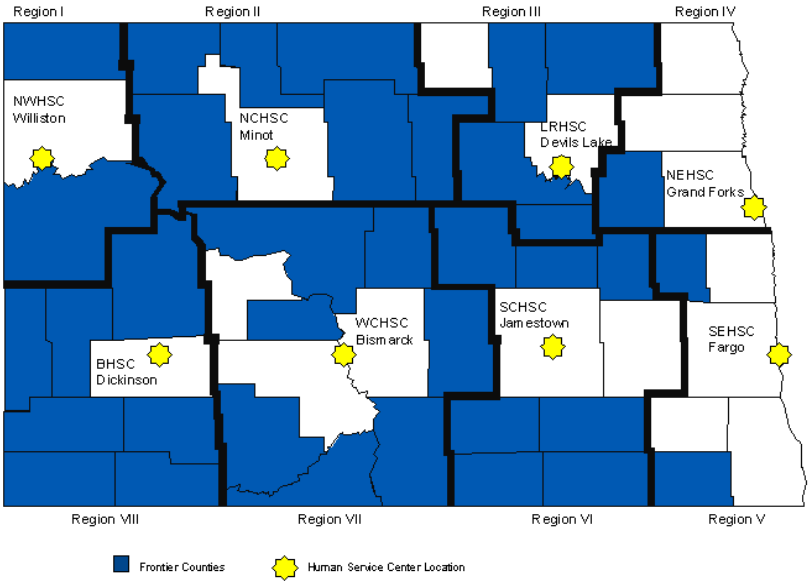
Northwest Human Service Center	Williston	Region I
North Central Human Service Center	Minot	Region II
Lake Region Human Service Center	Devils Lake	Region III
Northeast Human Service Center	Grand Forks	Region IV
Southeast Human Service Center	Fargo	Region V
South Central Human Service Center	Jamestown	Region VI
West Central Human Service Center	Bismarck	Region VII
Badlands Human Service Center	Dickinson	Region VIII

Consumers are served in the community through a variety of rehabilitation services including:

- crisis stabilization and resolution;
- inpatient services;
- psychiatric/medical management including medication management and other health services;
- social services;
- residential services and supports;
- vocational and educational services and supported employment;
- social and leisure activities;
- evidence-based practice of IDDT;
- evidence-based practice of Supported Employment;
- substance abuse services.

Services at the regional human service centers are provided to all consumers regardless of the consumer's race, color, religion, national origin, sex, age, political beliefs, or disability in accordance with Title VI of the Civil Rights Act of 1984, Section 504 of the Rehabilitation Act of 1973, The Age Discrimination Act, the Americans with Disabilities Act of 1990 and the North Dakota Human Rights Act (NDCC Chapter 14-02.4), 42CFR, and HIPAA. All services are provided to Native Americans living on or off the reservations.

Figure 1: Regional human service center locations and frontier counties in North Dakota



Regional Intervention Service

The Regional Intervention Service (RIS) provides 24-hour, seven days per week crisis assistance enabling the consumer, family, and significant others to cope with emergencies while maintaining the consumer in the community. With an interdisciplinary team that may include a psychologist, masters-degreed social worker, masters-degreed human relations counselor, psychiatric nurse, psychiatrist, and/or a licensed addiction counselor, Regional Intervention Service is able to provide the consumer with the best suited crisis intervention including short-

term crisis residential placement and immediate access to a range of housing, medical, and counseling services within the community.

In addition, the Regional Intervention Service team has the responsibility of evaluating consumers who may need referral to the North Dakota State Hospital, ensuring that consumers are provided with the least restrictive treatment environment. The Aftercare Coordinator, a member of the Regional Intervention Service team, coordinates discharge planning with North Dakota State Hospital staff providing a smoother transition and greater community linkage to the consumer upon return to their region.

Prevention System – Local Services

The Division provides local level substance abuse prevention services through a Targeted Communities program. North Dakota communities will have access to targeted substance abuse prevention services at the local level that will be guided by Community Prevention Specialists. Local North Dakota communities are able to apply to become a Targeted Community, where Community Prevention Specialists will provide technical assistance and support in implementing the Strategic Prevention Framework. Targeted Communities will receive guidance identifying goals, implementing effective and culturally appropriate strategies and evaluating community progress with a focus on sustainable, environmental efforts. Targeted Communities will also receive additional technical assistance as needed by Prevention Specialists with focuses in particular areas such as education, criminal justice, law enforcement, workplace wellness, and media. There are currently five Targeted Communities being served encompassing both rural and urban communities across the state.

Local substance abuse prevention funding is distributed to the four federally recognized Native American Reservations, which have been identified as high risk (which accounts for only 3.5% of North Dakota's population, 2000 Census). There is a Tribal Prevention Coordinator in each of the four Native American Reservation in the state. The Tribal Prevention Coordinators provide culturally appropriate technical assistance and assist in implementing evidence-based substance abuse prevention strategies. Tribal regions will also receive additional technical assistance as needed by Prevention Specialists with focuses in particular areas such as education, criminal justice, law enforcement, workplace wellness, and media.

Medical Services

Medical services at the human service centers include the delivery of medication monitoring, medication administration, psychiatric evaluation, and psychotherapy/treatment by a licensed psychiatrist. Some services are delivered by a licensed psychiatric nurse or licensed nurse practitioner under the supervision of a physician.

All clients who receive services from the public behavioral health system, including adults diagnosed with serious mental illness, children diagnosed with serious emotional disturbances, and individuals in need of substance abuse treatment, have access to medical and dental services provided by local private physicians and local general hospitals. Services are paid for by the consumer, consumer's insurance or medical assistance if the consumer qualifies. Case management staff in the human service centers work closely with consumers to ensure that their medical and dental needs are met.

Psychological Services

These services, under the direction of a full-time licensed psychologist, include psychological evaluations, psychotherapy, and case and program consultation. Psychologists assist in developing treatment plans and diagnosing persons with mental illnesses.

Mental Health Disorder Treatment

Acute treatment, provided by a range of mental health professionals including social workers, psychologists, and case managers, refers to individual, group, and family therapy that is generally short-term in nature. Therapists use varied approaches to therapy including cognitive-behavioral, Gestalt, and psychodynamic techniques. When appropriate and with permission of the consumer, family members and/or significant others are involved in therapy to enhance the process.

Alcohol and Drug Addiction Services

These services, provided to adults and adolescents, include addiction evaluation; intensive outpatient programs; day treatment; individual, group, & family therapy; pre-treatment programs; and the treatment recidivist program which includes social detoxification, short-term residential, and a case manager aide program.

Outreach

The service areas for eight regional human service centers range from three to ten counties. Each center has staff traveling to outlying rural communities and Native American reservations to provide mental health services.

Outreach substance use disorders services are provided in rural counties when feasible. Each of the regional human service centers employs licensed counseling staff to work either full-time in outreach areas or sends a licensed addiction counselor to outreach areas regularly, based on need for services. The regional human service centers promote awareness of services to outreach areas through communication with referring agencies, county courts, regional health units and county social service agencies. Services are also discussed through the local media, regional human service centers brochures, speaking engagements, listed in the directory of all ND licensed substance abuse treatment programs (listed first by region, then by city), on the web (including priority status), and in the phone book.

Educational Opportunities

Consumers are offered a variety of educational opportunities by Department staff, either through staff presentations or via arranged speakers. These can include presentations concerning Social Security and community programs. Consumers who desire to further their education – whether by obtaining their high school diploma/GED, college degree, or other opportunity – may be assisted by human service center staff with accessing appropriate programs. This may include referral to Vocational Rehabilitation for assessment and assistance or accessing information from an educational institution.

Vocational Rehabilitation

Vocational Rehabilitation provides and/or purchases services that result in competitive employment of eligible individuals with physical or mental impairments. Vocational Rehabilitation services include, but are not limited to, diagnosis and evaluation, vocational counseling and planning, information and referral, adaptive equipment, vocational training, job placement and follow-up.

THE BEHAVIORAL HEALTH SYSTEM OF CARE

MENTAL HEALTH

Individuals diagnosed with a serious mental illness, in most cases, are provided service through the Extended Care Treatment Units in each regional human service center. Below are the core services offered through the Extended Care Treatment Units, either directly or through public/private provider partnership or contracting:

Case Management: The mission of case management is to improve the quality of life and dignity of individuals with serious mental illness. Case management assists consumers with accessing the various services they need and want, and helping them make informed choices about opportunities and services in the community. The case manager helps ensure the consumer receives timely access to needed assistance, provides encouragement and opportunities for self-help activities, and provides overall coordination of services enabling the consumer to meet their goals. Case management is provided in the environment of the consumer's choice. Overall, services are provided to assist individuals to live as independently as possible while reducing the need for inpatient hospitalization and decreasing the risk of harm to self or others.

The goals of case management are:

- To provide for each individual a single point of referral to needed service within and outside of the mental health system
- To assure consumer access to appropriate services and supports
- To assure that services are not only relevant to consumer need but that services meet that need
- To ensure continuity of care and coordination of service provision for consumers, including transfers from community to hospital and back
- To educate consumers in how to negotiate the mental health and social services system when needed or desired

- To empower consumers by enabling them access to experience new opportunities, roles, and responsibilities
- To integrate consumers into normalized community living, i.e., providing a place to live, work, and learn in the environment of their choice
- To provide therapy, supportive counseling, and daily living skills training as needed and appropriate to consumers
- To assure all interventions are planned and carried out in a real partnership between the consumer and team members.

Community Residential Options: Housing options available to adults diagnosed with a serious mental illness who are receiving services through the regional human service centers include:

- Nursing Facility - A twenty-four hour highly supervised facility for consumers with medical problems. The human service center provides consultation/technical assistance and case management as requested.
- Long-Term Residential - Twenty-four hour supervised care providing room and board for five years or longer. The human service center provides or contracts for consultation/technical assistance and case management as requested.
- Transitional Living -Twenty-four hour minimal supervision, six to eight consumers in a group setting, room and board provided up to one year. This is provided by the human service center or through a contract with a local provider.
- Homeless Shelters - Minimal supervision, one night to several months as needed, room and board provided. The human service center provides case management as requested.
- Single Room Occupancy - House managers live in the facility and provide minimal supervision. Peer support and case management is provided by the agency operating the facility. The human service center provides case management as requested.
- Supported Housing - Independent living arrangement with staff and financial support from the agency operating the facility. The human service center provides case management and financial support as needed and requested.
- Independent Living - Independent living apartment rented by the consumer with case management and skills training provided if requested by the consumer.
- Fairweather Lodge Program - a program dedicated to improving the lives of adults with mental illness by providing safe, affordable housing, employment and social services.

Recovery Centers: There is a Mental Health Recovery Center located in each of the 8 regions of North Dakota. Each Regional Human Service Center contracts with a private entity to administer the centers. The purpose of the Recovery Centers is to offer an environment of learning that promotes wellness and personal growth designed to empower individuals in recovery to live more meaningful lives in the community. Recovery Centers are member-operated and promote recovery through peer support, socialization, education, and training. By working together, members pursue life goals, build better lives for themselves, gain employment, maintain independence and become a part of their communities. The Recovery Centers offer groups, activities and resources that will empower the members to work, volunteer, attend school or further enrich their lives as they work towards recovery.

Supported Employment (Extended Service): This is a service designed to provide ongoing employment-related support for individuals in supported employment upon completion of training which may include job development, replacement in the event job loss occurs, job training contacts, and other support services as needed to maintain employment.

Community Supportive Care Program: The Community Supportive Care Program uses community people to provide emotional and other types of support within their communities to persons with serious mental illnesses. The volunteers/companions are selected because of their human qualities that enable them to respond skillfully to human needs. All of these people volunteer on a part-time basis. The volunteers/companions meet regularly with clinical staff at the human service center to review cases and complete administrative functions. The training that volunteers/companions receive comes through the reviewing of cases and discussion of problems.

Other Supportive Services: Adults served through the serious mental illness system of care access supportive services through other units of the human service centers. These services include group, individual, and family therapy, psychological services, and medication monitoring.

Peer Support Services - Peer Support Services are consumer centered services with a rehabilitation and recovery focus designed to promote skills for coping with and managing symptoms while facilitating the utilization of natural resources and the enhancement of community living skills. Peer Support Services are currently provided through 4 of the 8 Regional Recovery Centers, as well as the North Dakota State Hospital. Peer Support Services will be implemented in the remaining four Recovery Centers within the next several months.

Consumer Family Network – The North Dakota Consumer Family Network (CFN) is a consumer run organization, consisting of individuals and families dedicated to education, support, advocacy, and empowerment based upon the concept of recovery in the interest of promoting mental health.

In 1994, the Division of Mental Health Services applied for a comprehensive community mental health services grant from the Center for Mental Health Services targeting children and adolescents diagnosed with serious emotional disturbances. This $16.8 million grant provided the impetus for a formalized system of care for children and was implemented statewide. Services developed or enhanced through the grant include care coordination, respite care, non-hospital crisis, school-based day treatment, and intensive in-home therapy, all using the wraparound process. North Dakota was able to sustain core services developed through the grant effort and approximately 3150 children with serious emotional/behavioral disturbances have received services through the Partnership program through June 2010.

Key to the children's mental health system of care is a strong partnership with families and integrating services across systems. Parents are actively involved in the design and implementation of the programming, serve on the local and state advisory boards and provide on-going support to parents negotiating services for their children. The wraparound process, which uses a strength-based approach to service delivery, is used in this program and is a method shown to improve the functioning of children who have complex needs. The process is used to help communities develop individualized plans of care.

Working with the family, formal and natural supports (the child and family team) are wrapped around the family to provide them with the services/supports required to meet their needs. The wraparound process includes a set of core elements: 1) individualized plans of care, 2) culturally competent and tailored to the unique needs of families, 3) parental involvement, 4) strength-based, 5) least restrictive setting.

Below is the array of services provided through the **Partnerships Program** within the children's mental health system of care:

- **Care Coordination:** Care coordination assists children with serious emotional disturbances and their parents with accessing the various services they need and helps them make informed choices about opportunities and services in the community. The care coordinator helps ensure the child and parents receive timely access to needed assistance, provides encouragement and opportunities for self-help activities, and provides overall coordination of services enabling the child and parents to meet their own goals.

- **Case Aide**: This service is designed to provide behavioral management assistance and role modeling. Certified Mental Health Technicians help individuals stabilize, reduce, and eliminate undesirable behaviors that put them at risk of being served in restrictive settings. Certified Mental Health Technicians also help individuals observe and learn appropriate behavioral responses to situations that trigger their symptoms.

- **Flexible Funding**: This service is available when no other resources are available to meet specific needs and threaten the child's ability to remain in the least restrictive setting.

- **Crisis Residential Services**: This service provides a short-term, safe place to stabilize behaviors in a 24-hour supervised setting. The goal is to promote rapid stabilization and return to the home or community.

- **Substance Abuse/Dual Diagnosis Services**: When a child diagnosed with a severe emotional disturbance requires substance abuse treatment, a substance abuse provider becomes involved in the team process. With enhanced services made available through the SAPT Block Grant funding for adolescent services, service choices for the teams to consider are increased.

Other supports/services available within the children's mental health system of care:

- Inpatient Psychiatric Facility: This service component provides a short-term episode of care in a hospital setting for the purpose of crisis stabilization that cannot be managed in a non-medical setting, and for comprehensive assessment. The use of this service is reserved for extreme situations for youth who are showing serious acute disturbances or who have particularly perplexing behavior problems.
- Psychiatric Residential Treatment Facilities: A facility or a distinct part of a facility that provides to children and adolescents a total, twenty-four hour, therapeutic environment integrating group living, educational services, and a clinical program based upon a comprehensive, interdisciplinary clinical assessment and an individualized treatment plan that meets the needs of the child and family. The services are available to children in need of and able to respond to active psychotherapeutic intervention and who cannot be effectively treated in their own home, in another home, or in a less restrictive setting.
- Voluntary Out-of-Home Treatment Program: Is administered by the N.D. Department of Human Services through collaboration between the Division of Mental Health and Substance Abuse Services and the Children and Family Services Division. The program is an option for parents to access out-of-home treatment for their children without relinquishing legal custody when the child's circumstances fall within the intent of this program. The child must be covered by the Medicaid program and the application be approved by the Division. There were a total of 25 youth placed through this program from July 1, 2009 – June 30, 2011.

- Therapeutic Foster Care: Specially trained and supported foster parents who provide a home for generally one child at a time. The child may remain in the foster home indefinitely. Intensive training for the foster parents is provided, along with on-going intensive support and back-up by mental health professionals and care coordinators.
- Parent-to-parent support: This service includes coaching and assisting families with increasing their knowledge of their child's needs, the process of choosing service providers, explanation and interpretation of policies and procedures, and training to assist parents in accessing mental health services for their children. The Division of Mental Health and Substance Abuse awarded the contract to the North Dakota Federation of Families for Children's Mental Health to provide the parent-to-parent support services.
- Residential child care facilities: a less intensive service setting than a residential treatment center that provides 24-hour care.
- Employment Assistance: Children of working age in the system of care can receive employment assistance through the IEP process at their school. Once they have left the school system, Vocational Rehabilitation services are available. Partnership staff assist the child and family with accessing these services when needed.
- Other supportive Services: Acute, Psychological Services, and psychiatric services are available through the regional human service centers.
- Respite/Parent Support: Respite services provide families of children diagnosed with serious emotional disturbances with periodic relief or back-up assistance. These services may be on a planned or emergency basis and can be provided either in the family's home or in another setting.
- Intensive In-home Therapy: This service component provides crisis resolution and family therapy oriented services on an outreach basis to work intensively with children and families in their homes. Families that receive these services have a child who is at risk for out of home placement. The services are intensive with 24-hour availability. Services include (but not limited to) skills training and counseling.
- Transition to Independence Program: This service provides transition to independence process – wraparound case management services for transition aged individuals who are at risk between t he ages of 14-24. The Transition to Independence Program also provides technical assistance to other service providers who are working with transition aged individuals. This program became operational at all eight Human Service Centers on July 1, 2011.

SUBSTANCE ABUSE TREATMENT

Substance abuse treatment services offered in North Dakota follow a continuum of care as identified in North Dakota Administrative Code (NDAC) Chapter 75-09.1. The full continuum of care of North Dakota licensed treatment programs ranges from assessment and early intervention services (such as the DUI Seminar, American Society of Addiction Medicine, Inc. (ASAM) level 0.5), outpatient services - adult and adolescent ASAM level I, intensive outpatient treatment - adult and adolescent ASAM level II.1, partial hospitalization/day treatment - adult and adolescent ASAM level II.5, clinically managed low-intensity residential care - adult and adolescent ASAM level III.1, clinically managed medium-intensity residential care - adolescent ASAM level III.5, clinically managed high – intensity residential care - adult ASAM level III.5, medically monitored high-intensity inpatient treatment - adolescent ASAM level III.7, medically monitored intensive inpatient treatment - adult ASAM level III.7, and social detoxification - ASAM Level III.2-D. Clients are seen for an assessment or through emergency services and then referred to the appropriate level of care, based on admission criteria as outlined in NDAC

Chapter 75-09.1 and current ASAM patient placement criteria. All levels of care and the admission criteria for levels of care are based on the American Society of Addiction Medicine Patient Placement Criteria (ASAM) a nationally recognized standard. DUI Seminar and inpatient treatment are provided throughout North Dakota, but SAPT Block Grant funds are not used for the provision of these services.

Allocations from the SAPT Block Grant Base funds for treatment services are allocated by a formula among the eight regional human service centers. Based on need, each center provides or contracts for appropriate services, offering a continuum of care.

Needs were identified by three regional human service centers (West Central Human Service Center, Lake Region Human Service Center, and North Central Human Service Center) for specific population of Native Americans. North Central Human Service Center used these funds via a contract to provide services to Native Americans on Ft. Berthold Reservation/Three Affiliated Tribes. Lake Region Human Service Center contracted for services for Native Americans on Spirit Lake Nation /Reservation and Turtle Mountain Band of Chippewa.

Multidisciplinary Case Conference (MDCC): Behavioral health treatment programs are required to staff all new admissions at a multidisciplinary case conference. North Dakota Administrative Rule requires services essential to the attainment of a client's goals and objectives to be provided or it must be documented that attempts were made to provide such services either through staff members or through formal affiliation or consultation arrangements with or referral to appropriate agencies or individuals.

The public behavioral health system already have an integrated electronic medical record and function under the same multi-disciplinary staffing team structure which assures individual care addresses both areas of need. These systems are co-located and function under the same administration, policy, and regulatory structure.

The regional human service centers collaborate to provide a continuum of care from education to treatment services. These services include vocational rehabilitation, acute clinical services, aging services, children and family services, developmental disabilities, psychiatric and psychological services, services for individuals seriously mentally ill and addiction treatment for all populations.

In 2011 the Assurance of Compliance with Rules and Regulations of applicable Federal and State laws and regulations, including the listing of specific SAPT Block Grand requirements was updated and signed by all human service centers.

NORTH DAKOTA STATE HOSPITAL

The North Dakota State Hospital, Jamestown, was established in 1883. The only state hospital in North Dakota, it is fully accredited by the Joint Commission on Accreditation of Health Care Organizations and is also Medicare certified. The North Dakota State Hospital is utilized only when it has been determined by the regional human service center to be the most appropriate option. The North Dakota State Hospital provides total care consisting of physical, medical, psychological, rehabilitative, social, educational, recreational and spiritual services through a variety of clinical and non-clinical staff. The goal of the treatment process is to implement appropriate therapeutic modalities at the earliest time so that the period of hospitalization can be reduced to a minimum. This requires integration with a system of aftercare services in the

community. North Dakota State Hospital staff work closely with community agencies on both a programmatic and an individualized basis to maintain continuity of care and treatment.

THE COUNTY SOCIAL SERVICE BOARDS OR DISTRICTS

There are fifty-three local county social service boards or districts. The county social service board delivery system is county-administered and state-supervised. The staff of county social service boards provide social support services primarily to the following target populations: children, adults and families, older adults, and those individuals with a physical disability.

In addition, county social service boards provide supportive services such as: home and community-based services; information and referral to individuals who have a chemical dependency, individuals diagnosed with a mental illness, individuals with a developmental disability, individuals with a physical disability, as well as other targeted population groups; parent aide and family preservation services – such as wraparound case management, Family Group Decision Making process/meetings, Kinship Care Program and intensive in-home service contracts – through the State.

Economic assistance programs administered by the county social service boards are financed through a combination of Federal, State, and local funds.

PROTECTION AND ADVOCACY SERVICES

Protection and Advocacy, a vital service in North Dakota, ensures the quality of services provided to consumers. Protection and Advocacy services to individuals with mental illness and serious emotional disturbances are provided by the North Dakota Protection and Advocacy Project, an independent State agency. The Protection and Advocacy Project employs full-time mental health advocates who are located across the state providing services at no cost to individuals with a mental illness and serious emotional disturbances. Services include information/referral, case advocacy, legal counsel, and protective services.

Advocacy services are easily available to ensure the protection of consumer rights and to help provide access to entitled services. Advocates ensure that grievance procedures and other mechanisms to protect the rights of consumers are in place and utilized in mental health and residential facilities. Legal services are available to protect consumer rights, to obtain entitled services, and to represent consumers in administrative and judicial proceedings.

PROGRAMS WITHIN THE SYSTEM OF CARE

North Dakota's public behavioral health delivery system is a coordinated, interagency effort. The growth of the community-based behavioral health delivery system in North Dakota has resulted in a decline in the daily inpatient census of the North Dakota State Hospital from over 2,000 individuals diagnosed with a behavioral health disorder in the 1950's to approximately 150 today.

STATEWIDE PLANNING PROGRAM: The planning process in North Dakota continues to evolve. The Division works closely with the human service centers in planning for the behavioral health system of care. The Division meets quarterly with each regional human service center's program staff to plan and implement community-based services statewide. The human service

centers regularly meet with regional stakeholders. In addition, region-specific planning meetings are held in every region throughout the year. The format of these meetings varies from region to region. Some choose to hold separate planning meetings with the local stakeholders. Others invite stakeholders to the Human Service Center Advisory Council meeting and conduct the planning in conjunction with that already-scheduled session. Additional regional planning is conducted through the Regional Children's Services Coordinating Committee, which is coordinated through the regional human service center.

The Statewide Planning Program is utilizing data gathered through Decision Support Services Unit to make informed planning choices. The Planning Program will continue to be refined during the upcoming years and data gathered by the Decision Support Services Unit will be used by regional planning representatives and Division staff to develop new initiatives and enhance existing programs.

From 1999 through to the present, the Department of Human Services has engaged in strategic business planning. This process has allowed the Department to better align systems, including the community-based mental health system. As a part of this process, the Department held Regional Stakeholder Meetings for the last three bienniums. Organizations and individuals involved in the delivery of human services in North Dakota, clients, policymakers, and the public are invited to attend and discuss community needs, capacity, and resources. The Division and the Planning Council are active players in this process, ultimately providing for a stronger public behavioral health system throughout North Dakota. Using SAMHSA's eight strategic planning initiatives, the Council identified priorities, objectives, and strategies plus the related measurement mechanisms. Past planning council documents include white papers to address the Council's Goal #2: Mental healthcare is consumer and family driven and Goal #5: Excellent mental health care is delivered and research is accelerated, and Goal #4: Early Mental Health Screening, Assessment and Referral to services are common practice.

The Division also assisted in developing Talking Points correlating to their position papers. The Division Director, Chair and Vice Chair of the NDMHPC met with the Governor's Office to share their stories about the Council, their involvement with the MH System of Care and provided the position papers and talking points.

REDUCTION IN HOSPITALIZATION: During the past few years the Department of Human Services has implemented programs to decrease the number of admissions to the North Dakota State Hospital. For instance, regional human service centers established diversion programs and dramatically decreased the number of hospital admissions. In fact, during FY 1998 there were 1,764 admissions to the State Hospital. This past year, however, showed only 647admissions. In addition to the diversion programs, Section 25-03.1-04 of the North Dakota Century Code – as amended by the 1999 Legislature – requires that all admissions to the North Dakota State Hospital be screened at the regional human service centers prior to being admitted. Like the diversion programs, the overall goal of this amendment was to develop additional services in the community, enabling the consumer in a time of crisis to remain in their community rather than having to be transferred to the State Hospital for treatment.

The North Dakota State Hospital continues to support the evolution of community-based services. It works in collaboration with the Division, regional human service centers, consumers and family members, the Mental Health America, the National Alliance on Mental Illness, Protection and Advocacy, the judicial system, local private providers, and other stakeholders to enhance current community-based programs and to design and implement new ones.

MEDICAL SERVICES: People who receive services through the public behavioral health system in North Dakota have access to medical services provided by local private physicians and local general hospitals. The consumer, consumer's insurance or medical assistance pays for services if the consumer qualifies. Case management staff in the human service centers work closely with consumers to ensure that their medical and dental needs are met. In addition, screening for enrollment in public health insurance programs is conducted by Community Resource Coordinators (CRCs) located in participating hospitals, clinics and public health departments. CRCs work one-on-one with people without health insurance to help them apply for free or low-cost insurance coverage.

In addition to health insurance programs, Community Resource Coordinators link people with other assistance programs, including: Women's Way, Children's Special Health Services, Child Care Assistance, Food Stamps, Heating Assistance, Vision Programs, Hearing Programs, and Women, Infants and Children (WIC). Medicaid offers a chronic illness management program for chronic illnesses.

Community Resource Coordinators assist needy people in applying for free or low-cost prescriptions through pharmaceutical companies' Prescription Assistance Programs. CRCs screen people for eligibility, help those who qualify complete applications, provide instructions on compiling documentation and complete other necessary processes to ensure that people get the medications they need.

Diabetes is a growing concern throughout the population in North Dakota. Recognizing this, the Dakota Diabetes Coalition was formed. This coalition, initiated by the ND Department of Health's Division of Chronic Disease, is a new statewide effort to improve diabetes prevention, self-care and treatment. This coalition has wide support because members work in teams on issues they deem most pressing. The Coalition endorses a two-pronged approach: diabetes control and diabetes self-management.

Diabetes Control - Part of this effort is to help clinics and hospitals improve their quality of diabetes care. Through a collaborative effort, doctors, nurses and other health care providers learn how to adjust their practices -- so that patients routinely get state-of-the-art diabetes care. This collaborative effort helps clinics challenge themselves to change how diabetes care is delivered. Those changes will result in a more satisfying professional life for doctors, nurses and dietitians. Meanwhile, patients benefit from a reinvigorated clinic atmosphere dedicated to patient care that is based on medical evidence.

Diabetes Self Management - Patients are key to diabetes control and they need the right tools in order to regularly test their blood sugar and follow their care plans. Many people cannot afford the test strips and other supplies that they need to take care of themselves. That is why this grant provides patients with vouchers for diabetes supplies. While there are programs available to help low-income people with medications, virtually no other program supplies test strips for people in need.

EVIDENCE-BASED PRACTICE: North Dakota has made great strides in community-based behavioral health care. In an attempt to address system gaps and maximize community-based services, North Dakota is exploring various evidence-based practices. The Director of the Division of Mental Health and Substance Abuse Services held monthly teleconferences with staff from the regional human service centers to discuss the specifics of evidence based

practices and the feasibility of implementing them. Topics included Programs of Assertive Community Treatment, Illness Management and Recovery, and Peer Support. Also, the annual conferences – the Substance Abuse Summit and the Clinical Forum on Mental Health – focus on evidence-based practice, behavioral health recovery, and behavioral health transformation.

Integrated Dual Disorder Treatment: Southeast Human Service Center provides Integrated Dual Disorder Treatment (IDDT) programming with consumers diagnosed with mental illness and co-occurring substance abuse disorders. Consumers are served by two teams for those who meet criteria for Quadrant 4, severe and persistent mental illness and chronic substance abuse. Between the two teams, 75-80 consumers are receiving services at any given time. In September of 2010, annual fidelity reviews were conducted by consultants from the Center for Evidence Based Practices at Case Western Reserve University. Southeast Human Service Center received an overall rating of 4.2 out of a possible 5 for services provided by Team 1 and an overall rating of 3 for services provided by Team 2. Please note that Team 2 was developed and began providing services to consumers who meet criteria for Quadrant 4 in May 2010. Prior to May 2010, the team had been providing services to consumers who met criteria for Quadrant 3, less serious mental illness and chronic substance abuse. Consumers who met that criteria are now being served by the substance abuse unit at Southeast Human Service Center. The action plan has been revised based on the results and recommendations of the review to reflect ongoing work towards continued fidelity-to-model. Staff at Southeast Human Service Center and the Division of Mental Health and Substance Abuse Services continue to work closely with consultants from Ohio SAMI CCOE, Case Western Reserve University, on this project.

Over the past two years, Division of Mental Health and Substance Abuse Services staff, in close collaboration with staff from Southeast Human Service Center have conducted a number of readiness meetings with a team of staff from South Central Human Service Center to assist in exploring their interest in implementing IDDT programming. Staff have participated in basic IDDT training and a more formalized overview of IDDT conducted by Southeast Human Service Center. A steering committee has been developed, a team lead has been identified, and a group of staff are working on program criteria. Two other regions in the state, West Central and Lake Region, have identified an interest in beginning readiness meetings. A formal meeting including the consultants from Ohio SAMI CCOE was held with a select group of staff from Lake Region Human Service Center in September of 2010. The Division of Mental Health and Substance Abuse Services, in conjunction with a consultant from the Center for Evidence Based Practices at Case Western Reserve University, has scheduled a two day training on IDDT implementation for staff from all eight human service centers and the ND State Hospital for August 29-31, 2011. The goal of the training is to provide information on the implementation of IDDT and provide each regional center and the hospital with the opportunity to discuss/assess their readiness to implement IDDT.

Implementation of an inpatient adaptation of IDDT at the ND State Hospital continues. The first annual fidelity review was conducted by consultants from the Center for Evidence Based Practices at Case Western Reserve University and staff from the Division of Mental Health and Substance Abuse Services in September 2010. Results of the review indicate an overall rating of 3 out of a possible 5. The hospital has updated their action plan based on the results and recommendations of the review to reflect ongoing work towards continued fidelity-to-model. As implementation continues, this level of inpatient programming will greatly enhance continuity of care and transition for consumers who return to their home communities. Staff from Southeast Human Service Center and the hospital work in close collaboration with consumers they currently have in common now.

Supported Employment: In March 2009, a pilot project of the evidence-based practice Supported Employment was implemented into the IDDT program at Southeast Human Service Center. The pilot was a collaborative effort between Vocational Rehabilitation, Southeast Human Service Center, the North Dakota Center for Persons with Disabilities Medicaid Infrastructure Grant, Community Options for Residential and Employment Services, Inc., and the Division of Mental Health and Substance Abuse Services. The baseline fidelity and two days of training were conducted in April 2009. An action plan was developed based on the results of the review. Community Options for Residential and Employment Services, Inc. is the provider of employment services. They employ an employment team of two employment specialists and a team lead. Each employment specialist provides services to up to 20 consumers at any given time and the team lead provides services to up to 12 consumers at any given time. The employment specialists and team lead are embedded into each IDDT team and a generalist team at Southeast Human Service Center. The annual fidelity review in March of 2010 was conducted by a consultant from the Center for Evidence Based Practices at Case Western Reserve University and staff from the Division of Mental Health and Substance Abuse Services. The results of the review indicated an overall rating of 3.8 out of a possible 5. The action plan was updated to reflect the results and recommendations of the review. The employment services provider relies heavily on the action plan to drive full implementation of the model. The annual review was conducted by staff from the Division of Mental Health and Substance Abuse Services, Vocational Rehabilitation, and Southeast Human Service Center in June of 2011. The results of this review indicated an overall rating of 4.32 out of a possible 5. Results and recommendations of the review will be used to update the action plan and guide the team towards continued fidelity-to-model. A satisfaction survey was distributed to consumers and team members in March of 2011. The results indicated that consumers are satisfied to very satisfied with and appreciate the employment services they receive, jobs group, and tours to job sites. Responses from team members ranged from satisfied to very satisfied as well. We are pleased to report that the budget for supported employment is now included in the overall budget for Southeast Human Service Center for 2011-13.

Evidence-Based Prevention Strategies: Science-based prevention has been identified as following a process of strategic planning that focuses on integrating thoughtful assessment, design, implementation, and evaluation into every program. The North Dakota Substance Abuse Prevention system utilizes the Strategic Prevention Framework to guide the selection and implementation of evidence-based prevention strategies by assessing data, ensuring capacity, and consistent evaluation. Current research on effective prevention strategies support the focus on implementing environmental strategies. Through the N.D. Substance Abuse Prevention Targeted Communities program, Community Prevention Specialists assist local communities in selecting, implementing, and evaluating culturally appropriate environmental strategies based on assessment of local data. Also, statewide prevention efforts include social marketing and media efforts to counteract pervasive social norms. Statewide and local efforts are also focused on ensuring adequate enforcement of substance-related laws and limiting access to substances.

Matrix**:** In 2005, Human Service Center Directors and the Division made a decision to begin training clinicians on evidence-based practices. ND began with the Matrix training. DMHSAS worked with Prairielands Addiction Technical Transfer Center (PATTC) to facilitate with UCLA to provide a two-day training of clinical staff and supervisors in Bismarck in April 2006. A second two-day MATRIX training for 20 clinicians and supervisors was held in May 2007. North Dakota sent 17 (11 in 2006 and 6 in 2007) supervisors to attend Key Supervisor Training at the Matrix Institute on Addictions. The process of MATRIX certification and fidelity continues. ND

currently has 3 Matrix Certified programs at West Central Human Service Center, Southeast Human Service Center, and North Central Human Service Center. The MATRIX model of treatment is now offered in each regional human service center.

Contingency Management – Motivational Incentive Program**:** In 2008, DHS issued a policy on Contingency Management – Motivational Incentive Program describing the program, including targeted behaviors, methodology and rewards, and the process for monitoring and accountability for the program. Full implementation was completed at each of the regional human service centers by January 2009. The primary objectives of utilizing a motivational incentive program are to increase: retention rates; the number of people attending treatment programming; the number of clients who participate in vocational, educational, and/or community support programs; the number of clients who achieve employment; and the number of clients who attain drug-free status. The targeted behaviors are to be individualized and each client who participates in this program will have an entry in their treatment plan. A clearly defined "fishbowl" method is used as described in the policy.

Treatment Collaborative for Traumatized Youth (TCTY) In 2007 the Division initiated Structured Psychotherapy for Adolescents Responding to Chronic Stress (SPARCS) and Trauma Focused Cognitive Behavioral Therapy (TF-CBT) as the two EBPs for children and families. The TCTY initiative is in collaboration with Dr. Steve Wonderlich, from the UND Medical School Neuroscience Department. The Division of Mental Health and Substance Abuse Services along with the Children and Family Services Division have made a commitment to support the continued implementation of evidence-based practices in both children's mental health and child welfare system for the next two years (2011-2013).

As of June 30, 2011, at the human service centers there are 44 clinicians and 13 supervisors training in Psychotherapy for Adolescents Responding to Chronic Stress (SPARCS) and Trauma Focused – Cognitive Behavioral Therapy. SPARCS is present-focused working with adolescents between the ages of 12-19 who have been exposed to events, such as, traumatic loss of a loved one, physical abuse, domestic and community violence, motor vehicle accidents, fires, tornadoes, hurricanes, industrial accidents, terrorist attacks, sexual abuse and other traumatic events/experiences equipping the youth with tools for coping with current and future stressors.

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The SPARCS & TF-CBT training is sponsored and conducted by the Neuropsychiatric Research Institute in Fargo along with the UND School of Medicine and Health Sciences. All Clinicians that are trained in SPARCS & TF-CBT will continue to have direct supervision that will occur for one hour, two times per month, for the first six months following training.

In October 2011 the Treatment Collaborative for Traumatized Youth will be adding the treatment method of Alternative for Families – Cognitive Behavioral (AF-CBT) as part of the evidence based practice training and therapy offered at the eight Human Service Center. AF-CBT is evidence based practice, family-centered treatment designed to address family conflict, coercion and hostility, emotional abuse, and child physical abuse. AF-CBT teaches individual and family skills to strengthen family relationships and safety routines using coordinated and

structured training methods. The goals of AF-CBT are to help family members improve their communication and problem-solving skills, help parents learn skills to effectively support and discipline their children, and help children manage difficult emotions and respond more positively to challenges.

This training methods seek to help family members improve their communication and problem solving skills, help parents to effectively support and discipline their children, and help children manage difficult emotions and respond more competently to interpersonal challenges.

There will be 24 AF-CBT program training slots offered to the Human Service Center Clinicians and Intensive In-Home Therapists. An application process will be used to select the 24 participants.

TRANSITION SERVICES: The 2006 Census estimates revealed that approximately 109,000 individuals in North Dakota were between the ages of 15 and 24. Although the children's population is declining, the complexity of their needs is increasing. There are recruitment and retention efforts – spearheaded by the Governor's Office – to maintain the young people in North Dakota. Despite efforts to offer incentives for North Dakotans to return to the state, the population continues to age.

The transition from adolescence to adulthood can be a difficult time for some. For those individuals who received services under the children's mental health system of care, attempting to navigate into the adult system can be a trying, daunting task. At times people find that services they received in the children's system are not available in the adult system or they simply no longer meet the eligibility criteria. In order to ensure that a full array of appropriate services are available during this critical time of transition, the Division will be working with consumers and family members, providers, advocates, and other stakeholders to identify gaps and develop and implement solutions to address this issue. The Adult and Children's Mental Health Administrators conducted statewide on-site meetings at all 8 Regional Human Services Centers in 2006-2007 to gather feedback and solutions to meet the needs of transitioning youth A statewide interactive video meeting was held on September 17, 2007. This meeting was an open forum for discussing youth transitioning from children's to adult MH services and also those youth aging out of foster care. Transformation Activities across the state, strengths and gaps in the MH system of care along with an update on Evidence-Based Practices was discussed. Participants included county regional representatives, Division of Juvenile Services, Independent Living Coordinators, tribal entities, county child welfare, and program administrators from the Division of Mental Health and Substance Abuse Services.

A legislative Interim Committee study was chosen to explore the needs of transition-aged youth in all systems: mental health, education, child welfare, juvenile justice, vocational rehabilitation and developmental disabilities. A collaborative effort among the systems has occurred to provide testimony and information to the committee. The Children's MH Administrator is also involved with a national transition aged youth workgroup, exploring areas such as housing, employment, involvement in policy building and testimony. The Department also has a Transition Steering Council that has been working on this area.

In April 2009 the House of Representative of the Sixty-first Legislative Assembly of North Dakota passed House Bill 1044 creating a program for services to transition aged youth at risk. The Division wrote administrative rules and is in the process of developing policy & procedures for wraparound case management services to transition aged youth at risk. In January of 2010 the Division received a Transformation Transfer Initiative Grant from the National Association of

State Mental Health Program Directors for a pilot project that provides wraparound case management services to transition aged youth at risk in the North Central Human Services Center in Minot, ND with the program being provided state wide in July 2011.

The Transition to Independence Program was launched at the eight Human Service Centers on July 1, 2011. The Transition to Independence Program will provide at risk individuals between the ages of 14-24 with wraparound case management services that use the Transition to Independence Process (TIP) that is evidence supported practice. There are 8.5 Transition Facilitators located in each Human Service Center who provide TIP case management to individual meeting eligibility criteria along with providing technical assistance to other service providers who are working with transition aged individuals.

As part of the Transition to Independence Program the Division of Mental Health & Substance Abuse has established eight regional Transition to Independence Subcommittees along with one State Wide Transition to Independence Interagency Advisory Council.

Regional Transition to Independence Subcommittees are currently being formed in each of the eight human service center regions with a implementation date of October 1, 2011. Regional subcommittee will be facilitated by the Transition Facilitator and consist of representatives of the various system partners such as education, juvenile justice, child welfare, tribal representatives, vocational rehabilitation, parents and youth, partnerships care coordinator, adult mental health case management services, housing authority, and community action. Members are selected based on their knowledge, understanding, and interest in the needs of transition-aged youth at risk. The purpose of the regional subcommittee is to advise the regional human service center on program and policy issues, delivery of services, and methods for reaching consumers. The regional subcommittee will meet on a regular basis (minimum of quarterly) as determined by the subcommittee and may combine with an already established transition committee.

In December of 2009, A statewide Transition to Independence Interagency Advisory Council was established that consists of representatives of the various system partners such as education, juvenile justice, child welfare, tribal representatives, transition facilitators, vocational rehabilitation, legislative assembly, parents and youth. Members were be selected based on their knowledge, understanding, and interest in the needs of transition-aged individuals who are at risk. The advisory council will advise the Department concerning program and policy issues, delivery of services, and methods for reaching potential consumers. The state-wide Council meets quarterly. The council will be facilitated by the program administrator from Mental Health & Substance Abuse with representation from the regional subcommittee to provide updates on a quarterly basis.

With the assistance of Olmstead stipends, the Division continues to provide a Transition Flex Fund. The Transition Flex Fund is intended to improve the flexibility of the system of care by establishing a pool of funds for young adults with severe emotional disorders who are transitioning to the adult mental health system. The goal is to improve overall level of functioning, self-sufficiency, and ability of the young person to establish/sustain life in the community. Since the establishment of the fund, 86 youth have been served.

In addition, the Department works closely with the Department of Corrections and Rehabilitation to ensure that individuals who have a serious mental illness and are in prison have a smooth transition once they are released. Through the Release and Integration Program, case

managers from the human service centers meet with inmates a few months prior to their scheduled parole to begin preliminary work on securing housing and any other needed assistance. The goal of this program is to assist the consumer with transitioning back into the community and – through the establishment of an informal and formal support system – help the consumer avoid re-incarceration. Also, the Director of the Division of Mental Health and Substance Abuse Services is in continued dialogue with the Director of the Department of Corrections and Rehabilitation concerning mental health services and the corrections system. This collaboration will continue to ensure that individuals with a serious mental illness who are in the corrections system have access to appropriate mental health services.

NETWORK FOR THE IMPROVEMENT OF ADDICTION TREATMENT (NIATX):
In 2006, Division staff and staff from two regional human service centers attended a process improvement orientation workshop. In 2008, North Dakota partnered with Prairielands Addiction Technology Transfer Center (Prairielands ATTC) to bring the NIATx project to ND. Three regional human service centers are participating in this project (Northeast Human Service Center - NEHSC, Lake Region Human Service Center - LRHSC and Southeast Human Service Center - SEHSC). These providers are examining their admission process and paperwork requirements. The rapid cycle change process is being used. The four aims from NIATx are increase admissions, increase continuation of services, reduce no-shows and reduce waiting times. Changes made to processes so far include eliminating a redundant admission form at NEHSC, resulting in 20-30 minute time savings for the client at admission, implementing a walk-in immediate care 'clinic' at SEHSC, resulting in clients being seen when they have the most need. These three centers are discussing other strategies for a reduction in no-shows. **LRHSC** is one of three HSCs that has established a NIATx change team and started to implement NIATx continuous improvement efforts toward successful consumer strategies and processes. The NIATx approach forms another core asset to the implementation of the "Pathways to Recovery" application. All centers participated in the paperwork reduction initiative.

AGING AND BEHAVIORAL HEALTH SERVICES: North Dakota is an aging State. It is estimated that approximately 147,706 people in North Dakota are 55 years of age or older. This is projected to increase to 241,496 or 62% by the year 2015. Kessler, as cited in the Surgeon General's report on Mental Health, estimated that 0.8 percent of persons over the age of 55 have a serious mental illness. Based on this, approximately 1,182 persons are aged 55 or above and have a serious mental illness in North Dakota.

It is recognized that a number of barriers exist for this population including difficulty accessing care due to the rural/frontier nature of North Dakota, lack of specialized geriatric behavioral health care, as well as stigma and misperceptions surrounding behavioral health in the aging population. For this reason, the Division of Mental Health and Substance Abuse Services is focusing attention on the enhancement of mental health services to the aged population throughout the State. During phase one of this initiative, the Division worked with the Mental Health American of North Dakota to develop and implement mental health and aging training programs to identify existing mental health services for older individuals, develop an understanding of those mental health services and collaboration among agencies, identify future service needs for the identified gaps, raise public awareness of the mental health needs of and services for older individuals. Trainings were at all human service centers to provide staff members with an understanding of the issues regarding behavioral health needs of the elderly and allow them to gain an appreciation for the multidisciplinary approach to meeting the health needs of older individuals. In addition, an aging/mental health track was incorporated into the Clinical Forum on Mental Health conference. Topics included the assessment of behavioral health issues in the elderly, substance abuse and the elderly, and understanding depression

and suicide in the elderly.

Phase Two of the initiative focused education to the natural caregiver – those individuals – generally outside of the professional medical community – that older individuals routinely access for care and support in the community. This included (but not limited to) nursing home staff, family caregivers, parish nurses, clergy, personal care attendants, and first responders. The training included discussion of the aging process, wellness and prevention, and information and resources. North Dakota State University was awarded the contract and has extensive experience in the field of gerontology and mental health. They developed a four module-training program focused on positive aging and mental health. Thirty-two natural caregivers representing each region of the state were trained to conduct education on mental health and aging. They presented the four modules throughout North Dakota. The total attendance at the education sessions was 727 natural caregivers. The modules have been catalogued with the North Dakota State Library.

Phase Three of the initiative expanded from the natural caregiver training. North Dakota State University developed and implemented a training curriculum on mental health issues and older adults targeted to community-based mental health clinicians. The curriculum focused on mental health and the aging process; changes to the aging brain and the impact on mental health, wellness/prevention/medical issues associated with mental illness; assessment and diagnosis of mental health issues in older adults; treatment of mental illness in older adults including psychopharmacological treatment, psychosocial treatment, and barriers to treatment and how to address them; and community resources. The training was structured as a web-based program, which included core information, case studies, activities, and resources. This program will be updated during the upcoming year and will also include information on the early diagnosis and treatment of Alzheimer's disease and dementia.

During the past year, the Natural Caregiver Program and the Mental Health Clinician Training Program was continued, allowing the Division to further increase the cadre of clinicians and others trained in mental health and aging. To date, nearly 40,000 Mental Health and Aging educational materials have been distributed. The material has been adapted for use by Native American communities and distributed to North Dakota reservations and organizations that serve the Native American communities.

EMPLOYMENT SERVICES: The Division uses block grant dollars to augment Extended Employment Services for adults diagnosed with a serious mental illness. These funds are used to purchase employment coaching/job shadowing as well as assistance with locating/obtaining/maintaining employment. This service is provided by private agencies statewide and overseen by eight Extended Services case managers, one in each region of North Dakota. The goal is to help those individuals who are diagnosed with a serious mental illness and have the desire to work to obtain and maintain employment in the community of their choice, ultimately leading to increased self-sufficiency. This goal supports the sixth SAMHSA Initiative which is to promote the behavioral health of individuals, families, and communities affected by the economic downturn, the employment of people with mental and substance use disorders, and policies for employers that support behavioral health in the workplace.

DUAL DIAGNOSIS (MI/SA) SERVICES: The North Dakota Department of Human Services provides service to individuals who are dually diagnosed with a serious mental illness and a substance abuse disorder. The regional human service centers offer dual diagnosis programs ranging from group therapy to intensive case management. For instance, located in Fargo, Southeast Human Service Center offers the intensive Off Main program. Off Main is a scattered

site residential program that provides rent subsidization, case management, medication monitoring, addiction counseling, family, group, and individual therapy to individuals who are dually diagnosed.

In addition to the dual diagnosis programming offered throughout the state, the Dual Diagnosis Education Group – a collaboration of public and private mental health and substance abuse providers in southeastern North Dakota – offers the annual Dual Diagnosis Workshop. Presenters at this workshop have included Christine Reilly of the Beck Institute, Dr. Ken Minkoff, and Dr. Bert Pepper. The Division of Mental Health and Substance Abuse Services is an active supporter of this training event.

To help coordinate dual disorder programs across the state, the Division of Mental Health and Substance Abuse Services hired an Administrator of Mental Health/Substance Abuse Programs. This position is responsible for planning, policy development and implementation, and program oversight of the MI/SA system of care across North Dakota.

NORTH DAKOTA CONSUMER AND FAMILY NETWORK: It is widely recognized that transforming the mental health system to be more responsive to consumer needs and better assist in recovery requires the participation of consumers at all levels of policy planning and program development, implementation, and evaluation. Meaningful involvement of consumers in the mental health system can ensure they lead a self-determined life in the community, rather than remaining dependent on the mental health system for a lifetime.

To ensure meaningful involvement of consumers in the mental health system, consumers and family members need to organize, encourage one another, and become educated about the workings of the system. The Division of Mental Health and Substance Abuse Services has long supported consumer participation in public mental health policy design and service implementation. This support continues with the statewide Consumer and Family Network.

The focus of this project is to develop a new or enhance an existing network of consumers of mental health services and their families dedicated to 1) organizing mental health consumers and family members in North Dakota; 2) promoting an environment of recovery from mental illness; 3) strengthening organizational relationships throughout the system of care; 4) promoting skill development with an emphasis on leadership; and 5) identifying technical assistance needs of consumers and family members and providing training and support to ensure that they are the catalysts for transforming the mental health and related systems in North Dakota. In 2007, Mental Health America of North Dakota received a contract from the Division to carry out these activities. They developed a curriculum focusing on leadership and advocacy skills and trained consumers and family members statewide. This contract was awarded to Western Sunrise, Inc. in 2008. Western Sunrise, Inc. is a consumer-run non-profit corporation in Williston, North Dakota. The organization consists of individuals and families with a focus on education, support, advocacy, and empowerment based upon the concept of recovery in the interest of promoting mental health.

Western Sunrise, Inc. completed year one of their contract on 6/30/09. A second contract has been awarded to them for the time period 7/01/09 though 6/30/11. The scope of service of the contract is to continue providing Recovery Leadership training sessions, maintain a designated number of consumers as “train the trainers“ of the Mental Health Recovery Model, continue providing Mental Health Recovery Model Trainings, and to continue with their membership recruitment plan.

The North Dakota Consumer and Family Network has the responsibility of implementing an annual conference. The initial conference was held in April, 2009, and the second conference in April, 2010. The Network did an impressive job with planning and carrying out the conferences. Both were well attended and well received.

MENTAL HEALTH TRANSFORMATION: Mental health transformation takes many forms in North Dakota. The process uses a multifaceted transition approach that infuses the recovery concepts within the services delivery while initiating targeted evidence based practice initiatives within regional human service centers that have displayed readiness for implementation. At the same time, consistent message, work force development, contracted initiatives, and technical assistance covering a variety of transformation areas take place. The next step is to create and promote readiness in additional centers for future expansion efforts.

The Division of Mental Health and Substance Abuse Services is leading the community-based public mental health system and its partners in implementing various mental health transformation activities. These include an anti stigma campaign, Integrated Dual Disorders Treatment pilot program at Southeast Human Service Center in Fargo, SPARCS, Trauma Focused Cognitive Behavioral Therapy, Mental Health Recovery, collaboration with the University System concerning Science to Services, implementation of the Mental Health Consumer and Family Network, Mental Health and Aging Education initiative, Early Childhood Screening Collaborative, SAMHSA's model of Supported Employment at Southeast Human Service Center in Fargo (in conjunction with IDDT), Person-centered Planning, Peer Support Services, Mental Health Recovery Celebrations and the development of a prevention/promotion framework.

The Division of Mental Health and Substance Abuse is engaged in a Recovery Project with the overall goal being: To transform Mental Health and Substance Abuse systems, policy, and services towards a recovery-oriented paradigm, responsive to the needs of people in or seeking recovery, as well as their family members.

The objective of the project is to provide information to system employees, partners, consumers, and their families for the purpose of introducing and/or clarifying:
the concept of Recovery; the Division of Mental Health and Substance Abuse movement towards a recovery-oriented system of care; and the Recovery-related components/services currently in place throughout the state.

The DMHSA recently implemented a Recovery Readiness Survey in each of the Regional Human Service Centers and Recovery Centers. The survey data will guide the North Dakota Department of Human Services, Division of Mental Health and Substance Abuse, policymakers, and ND advocates' efforts to provide and promote recovery-oriented person-centered mental health services throughout the state. The information will be used to develop ways to promote recovery and provide ongoing improvements in the way mental health services are provided in ND. The survey data will help to identify what is working well in the current ND mental Health service system and also identify challenges of the current system. The date will help to determine the level of recovery readiness of mental health service providers and guide future implementation of best practices. This information will assist in the development of next steps for possible improvements to the mental health service system.

RECOVERY: The concept of recovery shall be the guiding principle and operational framework for the system of care provided by the partnership of state and private agencies and consumer-

run services that comprise the Department's healthcare system. Services within this system shall identify and build upon each recovering individual's strengths and areas of health in addressing his or her needs. The environment for this system shall encourage hope and emphasize individual dignity and respect. As one of its foremost priorities, the Department shall promote recovery for persons at risk of, or who have psychiatric or substance use disorders by creating a recovery-oriented service system.

Recovery is a process rather than an event. Thus, the service system shall address the needs of people over time and across different levels of disability. Recovery principles shall be applied to the full range of engagement, intervention, treatment, rehabilitative and supportive services that a person may need. Recovery principles shall also be applied to health promotion and prevention services for those at risk of mental illness or of substance use disorders, especially those for whom selected or indicated prevention strategies are appropriate.

In keeping with this vision, and in partnership with the recovery communities, the Department shall create new and make necessary revisions to existing policies, procedures, programs, and services, and shall ensure that all new initiatives are consistent with a recovery-oriented service system. Finally, the Department shall ensure that future strategic planning and resource development efforts build upon existing strengths and continue to move the Department in the direction of promoting recovery as a core concept. In so doing, we shall firmly embed the language, spirit, and culture of recovery throughout the system of services, in our interactions with one another and with those persons and families who trust us with their care.

The recovery-oriented service system shall be notable for its quality. It thus will be marked by a high degree of accessibility, effectiveness in engaging and retaining persons in care such that they can achieve the highest degree of stability and recovery, and its effects shall be sustained rather than solely crisis-oriented or short-lived. To attain this level of quality, the recovery-oriented service system shall be age and gender appropriate, culturally competent, and attend to trauma and other factors known to impact on one's recovery. Whenever possible, services shall be provided within the person's own community setting, using the person's natural supports. The service system shall help the person to achieve an improved sense of mastery over his or her condition and assist the person to regain a meaningful, constructive sense of membership in the community.

Recovery Month Events: The Division of Mental Health and Substance Abuse developed a Recovery Month Event Toolkit in 2010. The purpose of the Toolkit is to assist communities with planning and funding Recovery Events held throughout the state. The Division of Mental Health and Substance Abuse Services offers stipends to eligible applicants to assist with funding these events. To date we have provided 4 stipends for events held in Bismarck, New Salem, Hebron, and Jamestown.

Recovery Month events provide a platform to celebrate people in recovery and those who serve them and serves to educate the public on substance abuse as a national health crisis, that addiction is a treatable disease, and that recovery is possible. Educating the public reduces the stigma associated with addiction and treatment. Involving community in advocacy and recovery celebrations helps change public perceptions of recovery, promote effective public policy and demonstrate that recovery is a reality for millions of Americans.

Events like rallies, runs, walks, sober social events or other activities educate people in our state about long-term recovery, engage kids and families in community-wide events, and demonstrate the joy and new life that goes along with recovery.

Recovery Centers**:** There is a Mental Health Recovery Center located in each of the 8 regions of North Dakota. Each Regional Human Service Center contracts with a private entity to administer the centers. The purpose of the Recovery Centers is to offer an environment of learning that promotes wellness and personal growth designed to empower individuals in recovery to live more meaningful lives in the community. Recovery Centers are member-operated and promote recovery through peer support, socialization, education, and training. By working together, members pursue life goals, build better lives for themselves, gain employment, maintain independence and become a part of their communities. The Recovery Centers offer groups, activities and resources that will empower the members to work, volunteer, attend school or further enrich their lives as they work towards recovery.

North Dakota Recovery Council**:** The Recovery Council was implemented in June, 2007. The purpose of the Council is to build a "Recovery Community" to enhance Recovery-Based services and supports for individuals following the formal treatment experience, to promote Recovery throughout the state, and to address the stigma associated with substance abuse. Membership includes Consumers, Division of Mental Health and Substance Abuse, Regional Human Service Center, Faith Based Community, Private Treatment Agencies, Tribal entities, Prevention Coordinators, Recoveree Connection, Probation and Parole.

Recovery Readiness Survey: The ND Organizational Self-Assessment for Recovery-Oriented Person-Centered Practices for Adults with Mental Illness a.k.a. ***The Recovery Readiness Survey.*** The Division of Mental Health and Substance Abuse Services partnered with the ND Center for Persons with Disabilities to conduct a set of surveys to gather information from adults receiving mental health services in ND and professional who administer mental health services in ND. The survey data will guide efforts to provide and promote recovery-oriented person-centered mental health services throughout the state. The information will be used to develop ways to promote recovery and provide ongoing improvements in the way mental health services are provided in ND. The survey data will help to identify what is working well in the current ND Mental Health service system and also identify challenges of the current system. The data will help to determine the level of recovery readiness of mental health service providers and guide future implementation of best practices. This information will assist in the development of next steps for possible improvements to the mental health service system. State agencies, policymakers, and advocates in building on the current system of mental health services in North Dakota.

Telephone Recovery Support**:** The "Recoveree Connection", North Dakota's Telephone Recovery Support Program, was implemented statewide in June, 2008. The Department of Human Services contracts with Rehab Services, a private agency located in Minot, North Dakota to administer the program. The Recoveree Connection is a non-clinical, volunteer based, support service whereby individuals in recovery from substance use disorders receive telephone calls from trained telephone recovery support specialists, most of whom are peers in the process of recovering themselves. Volunteers provide a "check-in" with the person in the early stages of recovery and help the individual to access community supports that further support the person's recovery in the community.

Peer To Peer Support**:** Peer Support Programs are located at each of the 8 Regional Recovery Centers, as well as the North Dakota State Hospital. Peer Support Services are consumer centered with rehabilitation and recovery focus designed to promote skills for coping with and managing symptoms while facilitating the utilization of natural resources and the enhancement of community living skills. Peer Support Services are provided by a person who has progressed in their own mental health recovery and is working to assist other people with mental health issues. Because of their life experience, peers have expertise that professional training cannot replicate. Peer Specialists foster their peer's ability to make informed, independent choices; help their peers recognize, and build on their strengths; and help their peers get the information and support they need from the community to make their goals a reality. Peer Specialists perform a wide range of tasks to assist peers in attaining their recovery goals. Peer Specialists undergo certification training and complete the certification process developed and recognized by the ND DHS.

The DMHSA hired a Peer Support Coordinator who oversees the Peer Support Programs across the state. This person is scheduled to attend Wellness Recovery Action Plan (WRAP) Training and will provide the information obtained to the 8 Regional Programs to enhance the utilization of WRAP across the state.

PERSON-CENTERED TREATMENT PLANNING: In an effort to improve documentation of medical necessity and help move the community-based public behavioral health system more toward person-centered care, the Department requested technical assistance from the National Technical Assistance Center. Dr. Neal Adams, Diane Grieder, and Dr. Ed Diksa were consulted concerning implementation of Treatment Planning for Person-Centered Care. This model was chosen because it not only represents a growing and increasingly respected place in the national behavioral health care arena, but it also allows for the blending of valuing consumer strengths and goals while retaining recognition of the importance of good diagnosing and planning for the measurable clinical outcomes that reduce or resolve clinical barriers to consumer recovery. Fifty-nine staff from the regional human service centers received one-and-one-half days of preliminary training in this model. Phase 2 of the project consisted of training 24 human service center staff members as trainers of the model. This training was held in mid July of 2008. The trainers then returned to their human service center and began working with consumers on their caseloads to develop person centered treatment plans, with the continued consultation and guidance from the TA consultants. They also began training staff within the center on the practice. Phase III of the project has been the continuation and broadening of the activities of Phase II. Included have been training more clinicians on the model and modifying the Department's electronic record to aide in development of person-centered treatment plans and documenting medical necessity. Planning for Phase IV, which will occur during the upcoming fiscal year, is underway and will include further clinician and supervisor training as additional enhancements to the electronic record.

Training on stages of change and stages of treatment serves to compliment the work we are doing on person-centered treatment planning. Recognizing the importance of meeting the consumer where they are at, developing an open trusting relationship, and engaging consumers in their own care is critical to successful outcomes for consumers. This has been implemented statewide. A four-hour session on the training was offered at the 2011 Clinical Forum on Mental Health Conference. Staff from the regional human service centers, State Hospital, and various community providers were in attendance at the session. Clinicians providing services at the regional human service centers are beginning to complete a more formal "staging" of consumers as they work closely with them to develop treatment plans.

NDAC 75-09.1 requires substance abuse treatment programs to include in client records evidence of the direct involvement of the client in the decision-making process related to the client's program.

MOTIVATIONAL INTERVIEWING: ND partnered with Prairielands Addiction Technology Transfer Center (Prairielands ATTC) to provide training on Motivational Interviewing (MI) for clinical supervisors and clinicians for both mental health and addiction staff from the regional human service centers across ND. Prairielands ATTC identified: **Motivational Interviewing is a directive, client-centered counseling style for eliciting behavior change by helping clients to explore and resolve ambivalence**. This training was designed to introduce the spirit of MI and develop techniques in manifesting the spirit. In February 2009, training began for supervisors. This training included two-day three part training on Motivational Interviewing; Basic, Motivational Interviewing: Advanced, and Motivational Interviewing Assessment: Supervisory Tools for Enhancing Proficiency (MIA: STEP) (total of six days of training for supervisors). The training for clinicians was offered at four central locations in the state (Minot, Bismarck, Jamestown and Grand Forks). The clinician training included two-day two part sessions on Motivational Interviewing: Introduction: part one and part two, and Motivational Interviewing: Advanced: part one and part two (total of four days of training for clinicians). The last of these training sessions concluded November 18, 2009. Additional MI training is planned. As an effort to continue the MI spirit and maintain fidelity, motivational Interviewing Supervisor Coaching Calls began July 2010. The collaboration with Prairielands ATTC and the one-hour monthly coaching call with two trainers assisting mental health and addiction supervisors is planned through June 2013.

SERVICES TO SEXUAL OFFENDERS: The Division of Mental Health and Substance Abuse Services has had a contract with Counseling and Psychotherapy Centers, Inc. (CPC) of Needham, Massachusetts to provide community-based treatment services to high risk offenders and those who offend against adults since September 2006. The population of high risk offenders served includes those who no longer meet the criteria of sexually dangerous individual and are released from the civil commitment unit at the ND State Hospital.

CPC operates on the evidence based containment model of practice. Services are provided in the Bismarck, Minot, Grand Forks, Fargo, and Jamestown regions of the state. On any given day, approximately 80-85 offenders are receiving services. Containment teams including sex offender specific probation officers, sex offender specific clinicians, victim advocates, and polygraph examiners meet regularly to review the treatment progress as well as compliance with community supervision of each offender. Each team member plays a critical role on the team. In particular, the role of the victim advocate has been greatly enhanced over the past five years. Advocates have been trained to participate in offender treatment groups when the work of the group is focused on victim-related issues and to review and provide feedback about various offender assignments such as clarification letters and safety plans. The Chaperone Program component was implemented into the program in the fall of 2010. Potential chaperones for offenders in the Jamestown and Minot regions have been trained.
The Division of Mental Health and Substance Abuse Services facilitates regular meetings between the Governor's Office, management of the Department of Corrections and Rehabilitation, and management of the Department of Human Services to discuss the program. The Division of Mental Health and Substance Abuse Services also facilitates a workgroup of staff from the regional human service centers, ND State Hospital, and ND Developmental Center who provide evaluation and treatment services to sex offenders. The workgroup meets

on a quarterly basis to discuss issues related to services for low-moderate risk offenders against children, ongoing training needs, and overall program consistency.

INDIGENT DEFENSE SERVICES: The Commission on Legal Counsel for Indigents (CLCI) was legislatively established in 2005 pursuant to §54-61-01, et seq., of the North Dakota Century Code. The CLCI was formed after years of debate over the direction of the delivery of indigent services in North Dakota. The North Dakota Supreme Court and Indigent Defense Task Force sponsored a study conducted by the Spangenberg Group, and from those findings came the impetus to form the CLCI to take charge of the delivery of services.

Prior the CLCI becoming an executive branch state agency in 2005, the program of indigent services for defendants and respondents was administered by the North Dakota Supreme Court. The system consisted of all private contractors who would submit their bills and expenses to the District Judges for approval. The Judges assigned the cases and monitored the contracts. One of the CLCI's goals was to separate the judiciary from the delivery of indigent services and thereby avoid an appearance of conflict for the Judiciary.

The CLCI is governed by a 7 member board appointed by varying entities of the state; the North Dakota Supreme Court, the State Bar Association, the Legislature, and Governor's office all appoint representatives who serve staggered terms. The agency has an Executive Director, and Deputy Director, and an administrative office in Valley City, North Dakota, and six public defender offices located in Bismarck, Minot, Fargo, Williston, Dickinson, and Grand Forks, North Dakota. Since 2005, the Commission has adopted attorney performance standards for both adult and juvenile cases, adopted agency standards, policies, and forms, and submits a budget each biennium to the Governor and the Office of Budget and Management.

North Dakota presently has six full time public defender offices. They are located in Dickinson, Minot, Williston, Grand Forks, Fargo, and Bismarck. In each office there is a supervising attorney, and he or she takes criminal and juvenile assignments from the court staff. Those cases are assigned first to the public defenders, and then to conflict counsel who are area attorneys who have contracted with our agency to provide case-by-case service, or by attorneys who have contracted for monthly conflict services.

COLLABORATION WITH MILITARY SUPPORT ORGANIZATIONS: Increased demand for mental health and substance abuse services available in the public system will emerge as military personnel and their families feel more comfortable to seek services and/or exhaust services offered by the VA or other support systems. The ND DHS has participated on the Inter-Service Family Assistance Committee (ISFAC) for the past two years. ISFAC is a multi-agency committee dedicated to collaboration around the needs of military servicemen and women and their families. The ND National Guard, Office of Veterans Affairs and the VA are active participants on the TBI Advisory Committee and TBI Systems Workgroup. Current efforts are underway to collaborate with the Office of Veterans Affairs on a number of issues and projects, including planning of a Veterans Summit for 2012. This collaboration provides the opportunity to stay abreast of all the efforts across the state and to share information about agency resources and services. In past years, a number of training opportunities have been provided to staff on military related issues such as military culture and reintegration. These effort supports the third SAMHSA Initiative for military families with the goal of support of our service men and women and their families and communities by leading efforts to ensure needed behavioral health services and outcomes are successful.

OLMSTEAD: For the past five years, the Division of Mental Health and Substance Abuse Services has received Olmstead stipends from SAMHSA. Funds have been used to leverage other funding sources to assist in the implementation of the evidence based practices of IDDT and Supported Employment, to underwrite recovery events for consumers, and support transition-aged youth in their goals towards independence, including youth stipends for the second annual transition conference hosted by the ND Federation of Families in July of 2011. Division staff participate in the ND Olmstead Committee and attend the annual national Olmstead Conference.

GUARDIANSHIP SERVICES: During the 2005 Legislative Session, SB 2028 provided for a guardianship services system for vulnerable adults who are ineligible for developmental disabilities case management services. Forty thousand dollars was appropriated for this system. The Division of Aging Services within the Department of Human Services was tasked with overseeing the implementation of the guardianship services system. Because of the limited funding ($40,000) and the need for such services from this target population, it was planned that twelve adults diagnosed with a serious mental illness would receive guardianship services through this program. A Request for Proposal was drafted for this program and training was conducted for attorneys, judges, and human service center case managers concerning guardianships for vulnerable adults. Unfortunately, there were no responses to the Request For Proposal.

To meet the legislative mandate, it was decided that the North Dakota Department of Human Services would pay for adult emergency or full guardianship establishment fees. This includes the attorney's fee, filing fee, and other fees connected with establishing the guardianships. There is no ongoing daily rate of pay. The target population for the program was individuals diagnosed with a serious mental illness, persons with Traumatic Brain Injury or persons over the age of 60. The work with the attorney, families, and proposed guardian is the responsibility of the regional human service centers. The cost for establishing the guardianship cannot exceed $2,500.

This program has continued through the 2009-2011 biennium and utilization has increased. Funding for this biennium is nearly exhausted. For this reason, a budget request was made in the 2011 legislative session and funding increased to $105,000 and added a $500 annual payment to guardians..

SERVICES TO INDIVIDUALS WHO HAVE SUSTAINED A TRAUMATIC BRAIN INJURY: In March of 2007, the DHS was awarded a three year TBI Partnerships Implementation Grant from the Health Resource and Services Administration (HRSA). The goals of the grant were: 1) addresses infrastructure capacity through an advisory committee leading to a formal advisory board; 2) build capacity through a statewide TBI summit and expanding education through existing association conferences and medical education; 3) build capacity through the development of a screening tool process and efforts to address TBI needs of veterans; and 4) build capacity and cultural competence by developing a pilot demonstration program on peer mentoring. The grant supported individuals with TBI, their family members and caregivers, service providers, advocates, and others to work together to build a stronger, more viable service system. A need assessment conducted during the 2003-2005 TBI Planning Grant established four primary themes: 1) sustainability (inclusive of statewide infrastructure and capacity building elements); 2) education and awareness; 3) enhancement of services; and 4) tribal issues. These themes were utilized to establish the goals of the implementation grant are directly related to the findings of the assessment process. The goals of the grant were met. An active, committed group of individuals serve on the TBI Advisory Committee that meets on a

quarterly basis. Numerous educational and public awareness events and conferences were attended and/or sponsored by the DHS and Head Injury Association of ND. In 2009, the DHS looked to the TBI advisory committee to make recommendations about the budget planning process regarding TBI services for the 2009-11 biennium. Although the budget plan was not included in the final budget, it was a good start for both the Department and the advisory committee to confirm the importance of the committee within the Department and the Department's desire to expand services. To prepare for the 2009-11 legislative session, the advisory committee established a policy workgroup to follow proposed TBI legislation. The workgroup met bimonthly during the session and hosted two TBI education events at the capitol building to demonstrate the needs of individuals who have sustained a TBI. Individuals who have sustained a TBI and their family members were encouraged to participate and became strong advocates of the TBI program.

Two separate pieces of legislation related to TBI passed during the 2009 legislative session. The first directed the legislative council, during the 2009-11 interim, to study the impact on the State's human services system provision of services for individuals with traumatic brain injury, including veterans who are returning from wars,. The second law established TBI services to be administered by the Department of Human Services, including informal support services, prevention, and identification efforts; social and recreational services; quality control and training to case managers and other persons providing services to individuals; and the provision of increased and specialized vocational rehabilitation and consultation to individuals who have sustained a TBI for extended support for those individuals at risk of losing their employment upon exhausting their vocational services. This law also established that the Department of Human Services, as the lead agency, would at least annually call a joint meeting of the Adjutant General, the State Department of Health, the Department of Veterans' Affairs, and the Superintendent of Public Instruction to discuss the provision of services to individuals who have sustained a TBI. The Department has decided that these meetings will be held quarterly, instead of annually and will serve as a systems development meetings in conjunction with the continued work of the advisory committee.

The Department of Human Services determined that the informal support funds from the 2009 legislation would be best implemented by contracting with the Head Injury Association of North Dakota (HIA). Social and recreational services are provided by HIT, Inc., an agency with years of proven success in meeting the needs of individuals with head injuries. Pre-vocational skills services and mentoring is provided by another agency with years of proven experience in the field of employment services. Funds were increased to provide ongoing employment supports to individuals working with Vocational Rehabilitation. A TBI screening tool was implemented at the eight regional human service centers in March 2011. The screening tool has been integrated into the intake process for all consumers except those who apply for developmental disability services only. The goals of implementing the screening tool are to provide vital information to clinicians to better understand who they are providing services to, improve treatment outcomes for consumers, and to provide data to DHS to utilize in future service and budget planning. The systems development meetings serve as a venue for open discussions not only about service coordination and collaboration but more importantly about unmet needs of individuals with TBI and their family members. The results of ongoing meetings has the potential to influence ongoing decisions about services and system development.
Passing of legislation during the 2011 legislative session resulted in additional funding to the DHS to increase informal supports, public education and awareness, and peer mentoring in the eastern part of ND. The Head Injury Association will oversee the provision of these services.

SUICIDE PREVENTION: The DHS is an active participant on the statewide suicide prevention coalition. The coalition meets quarterly to address the needs of ND. In 2010, the coalition completed a strategic planning process to develop a plan. The goals of the plan are: 1) Establish a sustainable operating structure for the North Dakota Suicide Prevention Coalition and 2) Prevent suicide through reduction in risk factors correlated with suicide and early identification.

In August of 2011, the suicide prevention director at the ND Department of Health formed a taskforce to assist the DoH in developing a process to conduct a needs assessment in ND. DHS is an active participant in this effort. The needs assessment will be conducted with various stakeholders and possibly a statewide community assessment at some point.

The ND Chapter of the American Foundation for Suicide Prevention was formed in 2007. The Chapter supports the annual Out of the Darkness walks every fall since September of 2006, with additional communities sponsoring a walk each year. This fall, there will be 7 community walks. Proceeds from the walk continue to support national research and prevention efforts as well as local community efforts. A program administrator from the Division co-chairs one of the local community walks. In conjunction with the president of the ND Chapter, the program administrator has presented at a number of conferences.

Information from the work of the coalition and the ND Chapter of AFSP is disseminated to the DHS on a regular basis. The Division program administrator assists with identifying training needs within the department and works with conference planning committees to sponsor training sessions.

PROGRAMS WITHIN THE SYSTEM OF CARE FOR CHILDREN

IDEA Workgroup: A Collaborative effort exists between school systems, the Department of Public Instruction, the Department of Human Services, and families who have a child(ren) diagnosed with serious emotional disturbance. Issues concerning education and the Individuals with Disabilities Education Act are addressed as they impact functioning. Partnership Program staff work with all parties to achieve quality education and supports for children diagnosed with a serious emotional disturbance. A strengths assessment is completed based on life domains. Life domains impacted are addressed through the single plan of care, IEP and the child and family team process. Teachers are often and routinely members of these teams. Therapists routinely collaborate with education staff. Department staff and members of the Mental Health Planning Council are members of the State Advisory Committee on the Education of Children with Disabilities. In fact, the Chair of that committee is a Planning Council member. This committee was organized to make recommendations and to advise the Department of Public Instruction concerning the administration of, preparation of general regulations for, and evaluation of Special Education programs in the state. The chair and Division staff are involved with the Department of Public Instruction in the development of education standards for educators. The ED Guidance Task Force has completed its task of the development of the Guidance for Working with Children, Youth and Young Adults with Emotional Disabilities document. The final draft was reviewed by task force members before final dissemination. The document was developed to provide guidance to the North Dakota system of care that supports

children and youth birth to 21 years of age, with or at risk of developing emotional or mental health disorders and their families. The intent of the document is to increase understanding or requirements and practices among system partners that will lead to greater continuity and move closer to a true comprehensive system of care, clarify various laws, regulations or policies, especially where they impact eligibility decisions, strive for greater consistency in practice among school districts and provide information about best practice and strategies for intervention and support. In the end, the document was developed from a desire to ensure children and youth with behavioral and emotional needs are able to receive services that effectively address these needs.

Training for the ED Guidelines occurred statewide in three locations in April 2007. A Power Point presentation was developed, along with group exercises for the training event. The intended outcomes of the training are 1. A better understanding of eligibility criteria and available services in the systems of care; 2. Awareness of similarities and difference between partner providers; 3. Awareness of the benefits of working together to address the needs of families with children and young adults with emotional disabilities; 4. Information about additional resources and how to access new information and ; 5. Recognition of other providers to invite as team members and a beginning relationship between partners within a region.

This document is now accessible on the Department's website for easy access by parents, guardians, professionals, and youth.
North Dakota ranks 12th best among all states on child well-being according to the national 2010 KIDS COUNT Data Book, a state-by-state study that reports on the well-being of America's children. North Dakota ranked in the top 10 nationally in five out of the 10 indicators of child well-being.

REDUCTION IN HOSPITALIZATION: During the past few years the Department of Human Services has implemented programs to decrease the number of admissions to the North Dakota State Hospital. For instance, regional human service centers established diversion programs and dramatically decreased the number of hospital admissions. In fact, during FY 1998 there were 1,764 admissions to the State Hospital. This past year, however, showed only 75 admissions. In addition to the diversion programs, Section 25-03.1-04 of the North Dakota Century Code – as amended by the 1999 Legislature – requires that all admissions to the North Dakota State Hospital be screened at the regional human service centers prior to being admitted. Like the diversion programs, the overall goal of this amendment was to develop additional services in the community, enabling the child in a time of crisis to remain in their community rather than having to be transferred to the State Hospital for treatment.

The North Dakota State Hospital continues to support the evolution of community-based services. It works in collaboration with the Division, regional human service centers, children and family members, Mental Health America of North Dakota, the National Alliance for the Mentally Ill, Protection and Advocacy, the judicial system, local private providers, and other stakeholders to enhance current community-based programs and to design and implement new ones.

MEDICAL SERVICES: Medical services at the human service centers include the delivery of medication monitoring, medication administration, psychiatric evaluation, and psychotherapy/treatment by a licensed psychiatrist. Some services are delivered by a licensed psychiatric nurse or licensed nurse practitioner under the supervision of a physician. In addition, the human service centers contract with local hospitals for short-term emergency

mental health services. These are accessed when all other community resources have been exhausted.

Screening for enrollment in public health insurance programs is conducted by Community Resource Coordinators (CRCs) located in participating hospitals, clinics and public health departments. CRCs work one-on-one with people without health insurance to help them apply for free or low-cost insurance coverage. Programs people may qualify for include: Medicaid, Healthy Steps (CHIP), and the Caring Program for Children.

In addition to health insurance programs, Community Resource Coordinators link people with other assistance programs, including: Women's Way, Children's Special Health Services, Child Care Assistance, Food Stamps, Heating Assistance, Vision Programs, Hearing Programs, and Women, Infants and Children (WIC).

Community Resource Coordinators assist needy people in applying for free or low-cost prescriptions through pharmaceutical companies' Prescription Assistance Programs. CRCs screen people for eligibility, help those who qualify complete applications, provide instructions on compiling documentation and complete other necessary processes to ensure that people get the medications they need.

EVIDENCE-BASED PRACTICES: North Dakota has made great strides in community-based mental health care. Challenges do remain, however. Transition from the children's mental health system to the adult system can be a daunting task. In an attempt to address issues such as these and maximize community-based services, North Dakota is exploring various evidence-based practices. The Director of the Division of Mental Health and Substance Abuse Services held monthly teleconferences with staff from the regional human service centers to discuss the specifics of evidence based practices and the feasibility of implementing them. Topics included Programs of Assertive Community Treatment, Illness Management and Recovery, and Peer Support. Also, the annual Clinical Forum on Mental Health Conference held in May of 2009 focused on evidence-based practice, mental health recovery, and mental health transformation.

In the children's mental health system of care; children, youth and families have access to Wraparound case management (promising practice) and therapeutic foster care (EBP).

DUAL DIAGNOSIS (MI/SED/DD) SERVICES: The North Dakota Department of Human Services met with residential treatment providers and identified a gap in services for children with lower cognitive functioning who have emotional disturbances. This private provider will provide services to that population in another part of the state who have both SED/DD diagnoses. The reason for this geographic change is due to a decrease in referrals to the original private provider site, in that during the past year they have run 50 percent or less occupancy. The private provider has submitted a transition plan to the Department outlining the steps they have taken to ensure that the current residents receive appropriate discharge planning and services. The Department has approved this transition plan. The private provider also provides step-down services for youth in the PRTF level of care to their residential childcare facilities.

The Department was also working with Minot State University in submitting a 360-Planning Grant to identify additional methods to better serve this population. A task force was formed from the Institutional stakeholder meetings and the State Review team's trend observations.

The State Review Team supported the philosophy of the Single Point of Entry into Services, however a lack of resources prevented its fruition. Another area that is being addressed are young adults who are in the foster care system after the age of 18, have both developmental and mental health diagnoses and are in need of continued treatment. The Children and Family Services and the Developmental Disabilities Divisions are holding strategic planning meetings with various system partners to discuss viable solutions for these young adults transitioning from the foster care system into the adult system of care, which will lead to successful transitions. The Adult and Children's Mental Health Administrators met with the DD Coordinators to discuss transitioning concerns between the Children's and Adult Systems of Care.

To help coordinate dual disorder programs across the state, the Division of Mental Health and Substance Abuse Services hired an Administrator of Mental Health/Developmental Disabilities Programs. This position is responsible for planning, policy development and implementation, and program oversight of the SMI/SED/DD system of care across North Dakota.

DUAL DIAGNOSIS (SED/SA) SERVICES: The North Dakota Department of Human Services provides service to individuals who are dually diagnosed with a serious emotional disorder and a substance abuse disorder. The regional human service centers offer dual diagnosis programs ranging from group therapy to intensive case management.

To help coordinate dual disorder programs across the state, the Division of Mental Health and Substance Abuse Services hired an Administrator of Mental Health/Substance Abuse Programs. This position is responsible for planning, policy development and implementation, and program oversight of the MI/SA system of care across North Dakota.

MENTAL HEALTH TRANSFORMATION: Mental health transformation takes many forms in North Dakota. The process uses a multifaceted transition approach that infuses the recovery concepts within the services delivery while initiating targeted evidence based practice initiatives within regional human service centers that have displayed readiness for implementation. At the same time, consistent message, work force development, contracted initiatives, and technical assistance covering a variety of transformation areas take place. The next step is to create and promote readiness in additional centers for future expansion efforts.

The Division of Mental Health and Substance Abuse Services is leading the community-based public mental health system and its partners in implementing various mental health transformation activities. These include Trauma-Focused Cognitive Behavioral Therapy, SPARCS, Mental Health Recovery, collaboration with the University System concerning Science to Services, implementation of the Mental Health Consumer and Family Network, Early Childhood Screening Collaborative, implementation of SAMHSA's model of Supported Employment at Southeast Human Service Center in Fargo, Workforce Development in conjunction with WICHE, and development of a prevention framework.

AUTISM: The Department recognizes the need to explore and examine the growing concerns regarding children with Autism and Autism Spectrum Disorders (ASD) in North Dakota. A Governor appointed Autism Spectrum Disorder (ASD) Task Force was established by legislation in 2009. The Governor appointed task force will include State Health officer (or designee); Director, Department of Humans Services or Designee; Director, Special Education or designee; Executive Director; Protection & Advocacy or designee; Pediatrician with expertise in the area of ASD; Psychologist with expertise in the area of ASD; College faculty member with

expertise in the area of ASD; Licensed teacher with expertise in the area of ASD; Occupational Therapist; Health Insurance company representative doing business in ND; Representative of a licensed residential care facility for individuals; Parent of a child with ASD; Family member of an adult with ASD; and a Legislative assembly member. An initial plan was developed and the current Legislative Assembly is studying this issue to determine the best approach.
The Home and Community Based Services Autism Medicaid Waiver will provide intensive supports for eligible consumers less than five years of age who have received a diagnosis of Autism Spectrum Disorder and their families. This waiver began in November 2010 and utilizes an evaluation team and interventions specific to individual needs.

Minot State University was awarded a grant to provide education and services targeting rural areas of the state. The program is called Great Plains Autism Spectrum Disorders Treatment Program. The program includes service, information, research and training.

THE NORTH DAKOTA CHILDREN'S SOCIAL, EMOTIONAL AND DEVELOPMENTAL ALLIANCE: The mission statement of the Statewide NDSEDA is "A Collaborative Effort with system partners to promote an awareness and understanding of health, social and emotional well being of individual's birth to 21 and their families".

The North Dakota Children's Social, Emotional and Developmental Alliance (NDSEDA) is a statewide committee with over 30 members from a variety of disciplines to include; medical, human services, juvenile justice, tribal communities, and child protective services.

Through collaborative efforts with Medicaid Services, on October 15, 2010 NDSEDA and Medicaid Services held a statewide training for all state Health Tracks Screeners on the Evidenced Based Mental Health Screening Instruments that NDSEDA selected to be used during all Health Tracks Screenings. Medicaid services issued policy that requires all children who receive a Health Tracks Screening will also have their Mental Health assessed and appropriate referrals made based on the assessment results.

The NDSEDA continues to meet on a quarterly basis to complete the strategic planning process and strengthen on-going collaboration efforts.

HEALTHY NORTH DAKOTA EARLY CHILDHOOD ALLIANCE: The Program Administrator for the Children's Mental Health Services Programs continues to work closely with HNDECA on Children's Mental Health and Family Participation for the HNDECA strategic plan with efforts to increase work with individuals from the Native American Tribal Community. The Healthy North Dakota Early Childhood Alliance (HNDECA), comprised of an impressive group of over 50 agency, parent and advocacy organization representatives, developed as part of efforts to build a comprehensive plan for early childhood in the state of North Dakota. To support families and communities in their development of children that are healthy and ready to learn at school entry, collaborations and partnerships are being built through the HNDECA.

Funding for this initiative, called the Early Childhood Comprehensive Systems (ECCS) Grant, is from the federal Health Resources and Services Administration (HRSA). The goal of the ECCS grant is to develop and implement collaborations and partnerships to support families and communities in their development of children, ages 0 to 8, who are healthy and ready to learn at school entry. The role of HNDECA was to oversee the process, to assure that it met federal guidelines and to be good stewards of the planning funds.

The five essential areas in the planning phase of this initiative include Access to Health Insurance and Medical Home, Mental Health and Social/Emotional Development, Early Care and Education/Childcare, Family Support and Parent Education. Some of the key goals developed include:

- To establish critical pathways, including checks and balances, for (childcare) licensure standards and practices to assure uniformity of delivery statewide.
- To assure that all North Dakota communities will involve families in planning and implementation of children's mental health programs and services.

- To increase the number of health and dental care provider practices that incorporate the seven medical home core components (care that is accessible, family-centered, continuous, comprehensive, coordinated, compassionate and culturally effective).
- To assure that all parents, and persons in a parental role, of children aged birth through eight have access to parenting education.

OUTREACH TO HOMELESS – ADULTS

Homelessness continues to be an issue in North Dakota. The state lacks sufficient affordable housing, especially for low and extremely low-income brackets. The availability of housing options that serve people with differing levels of need is much more limited – transitional units, low demand housing, and supported permanent housing are in very short supply. "Deep subsidy" funds like the Section 8 voucher, which is the only way the chronically homeless will be able to afford to pay for the housing portion of permanent supportive housing, are limited. Some zoning laws in the state contain provisions that make it difficult to site group living facilities, which is the category most permanent supportive housing projects fall into. The specific regulatory language often involves definition of "non-household" living, rules regarding number of unrelated individuals per unit, and the requirement for public hearings associated with conditional use permits process. In North Dakota there is a willingness to tolerate chronic homelessness as an "acceptable" situation. In part, this belief is fostered by people's lack of direct experience with chronically homeless individuals. It is difficult to feel a sense of urgency about an issue with which one has little knowledge or first hand experience. The people of this state have a fundamental belief in "self-sufficiency." This belief often leads people to believe that the chronically homeless do not deserve help because they are not working hard enough to help themselves. Again, the belief itself is an obstacle to building support for the creation of housing options that specifically serve this population. At times, consumers have difficulty accessing available housing resources because of poor rental and credit histories and criminal backgrounds. In addition, very low or no income and an inability to afford rent, whether it is because they are unable to find a job where the pay is sufficient to cover housing costs or because they are unable to keep a job because of a disability.

The most recent Point-In-Time Survey found 1,126 homeless persons in North Dakota including 787 adults, 300 children and 39 persons for whom age was unknown. Of these, 277 people or 24% were long-term homeless. Forty-five percent of individuals noted a history of substance abuse while 35% indicated mental health issues. The following chart provides a regional breakdown of Point-In-Time Survey results.

- **Table 1. Homelessness in North Dakota by Region (January 27, 2010)**

	Adults	Children	Age Missing	Total Individuals	Chronically Homeless	Long-Term Homeless	Mental Illness	Substance Abuse
Region I	6	5	8	19	0	3	9	11
Region II	35	22	2	59	0	6	24	11
Region III	101	33	4	138	0	16	19	44
Region IV	73	34	4	111	6	18	40	37
Region V	280	60	7	347	49	111	66	167
Region VI	39	1	7	47	0	18	41	22
Region VII	230	142	6	378	8	100	121	208
Region VIII	23	3	1	27	1	5	9	12
Total - ND	787	300	39	1126	64	277	329	512

- It is anticipated that approximately 1,000 persons who are homeless or at risk of becoming homeless and have a mental illness or a co-occurrence of mental illness and a substance abuse disorder will be provided services during FY 2011. Eight regionally-based coordinators funded under the Projects for Assistance in Transition from Homelessness Grant provide persons who are homeless and mentally ill with intensive case management services including therapy, skills training, supportive residential services and coordinate obtaining other community mental health and addiction services from staff of the human service centers. Persons who are homeless and mentally ill are provided outreach services, screening for treatment services, housing services, and referral for health, education, and entitlements.

- The North Dakota Coalition for Homeless People, Inc. is the lead entity in the state working to decrease homelessness in North Dakota. Comprised of over sixty organizations (including the North Dakota Department of Human Services), the Coalition is committed to reducing the incidence of homelessness in North Dakota communities, assisting homeless individuals and families to move to self-sufficiency and permanent housing as quickly as possible, and ending chronic homelessness in North Dakota. The Coalition is also the lead entity for the statewide Continuum of Care process.

- In 2010, a total of $1.8 million was awarded in Continuum of Care grants to support local programs throughout North Dakota. These funds are expected to provide critically needed assistance to persons and families living without a home of their own. The following Continuum of Care Grants were awarded. Some groups have multiple projects:

Comeau Transitional Housing	SHPR*	$15,277
CVIC Hope Transitional Housing	SHPR	$95,845
FHRA Shelter Plus Care Renewal	S+CR*	$201,420
Florence Anderson Center of Hope	SHP	$72,387
HMIS #1 Renewal	SHPR	$30,000
HMIS#2 Renewal	SHPR	$44,072
NDAD SHP	SHPR	$34,184
Prairie Harvest Human Service		

Foundation Supportive Housing Project	SHPR	$84,999
Prairie Heights	SHPR	$46,676
Shelter Plus Care #1 Renewal	S+CR	$101,952
Shelter Plus Care #2 Renewal	S+CR	$112,680
Shelter Plus Care Vouchers	S+CR	$155,412
SHP-Transitional Housing Renewal	S+CR	$78,819
Sister Path	SHPR	$150,000
SW North Dakota Supportive Program	SHPR	$37,600
Supportive Housing Program	SHP	$48,258
YWCA Cass Clay	SHPR	$80,504
YWCA Cass Clay	SHPR	$134,277
North Dakota Emergency Shelter Grant Funding:		$276,869
North Dakota CoC and ESG Funding:	Total	$1,801,231

- In addition to these projects, partnerships between local stakeholders have increased housing options for individuals diagnosed with serious mental illness in many regions. For instance, North Central Human Service Center, in partnership with other public and private stakeholders, is developing Harmony Heights, a four-apartment housing program located above the psychosocial rehabilitation center in Minot. With a case manager located on site, residents will have greater access to services, helping them remain in the community.

- The past few years have been pivotal for engaging both local and state elected officials in the work toward the goal of ending chronic homelessness. The Governor of North Dakota met with Coalition members in August 2004 to discuss developing a 10-year plan for ending chronic homelessness. Working with Coalition members, the Governor committed to having a plan in place and -- by Executive Order -- established a 19-member North Dakota Interagency Council on Homelessness (NDICH) to develop the plan. The NDICH reports to the Governor and the North Dakota Legislature, which assembles biannually. In addition to state agency directors and NDC members, elected officials included on the NDICH are Dr. Wayne Sanstead, Superintendent of Public Instruction and Mayors Warford, Walaker, and Brown of the cities of Bismarck, Fargo, and Grand Forks respectively. Ten-year plans have been developed or the cities of Bismarck, Fargo, Grand Forks, Minot, Jamestown, Williston, Dickinson, and Devils Lake. In addition, the Three Affiliated Tribes and the Turtle Mountain Band of Chippewa Indians have each developed 10-year plans.

OUTREACH TO HOMELESS –CHILDREN

Statistics for the education of children and youth under the McKinney-Vento Act were collected from all public school districts in the state of North Dakota for the 2006-2007 school year. The McKinney-Vento program is a sub-program of Title I, Department of Public Instruction.

Grade Levels
A total of 1,209 students, from school districts throughout the state, were reported as experiencing homelessness. Statistics listed below provide a breakdown by grade levels.

• 24% or 294 in pre-k and kindergarten

• 34% or 409 in grades one through five
• 17% or 199 in grades six through eight
• 25% or 307 in grades nine through twelve

Living Conditions
Living conditions of children and youth experiencing homelessness vary greatly. Some are living in shelters and others are living in unsheltered areas, i.e. car, tent, park. Statistics listed below provide living conditions of those identified as experiencing homelessness.

• 41 % or 492 children and/or youth lived in shelters
• 45% or 541 lived with friends or relatives, also recognized as “doubled-up”
• 10% or 126 lived in hotels/motels
• 4% or 50 children were reported as being unsheltered

Barriers
Barriers reported by school districts that may inhibit the education of children and youth experiencing homelessness include:

• Domestic violence
• Lack of adequate housing
• Lack of transportation
• Lack of adequate support system (family and friends)

Concerns
Concerns regarding the welfare and education of these children are many. The list below provides those most evident when addressing homelessness.

• Need for special services for children (i.e., special education and/or tutoring)
• Lack of parental involvement in the education process
• Need for counseling
• Need for collaboration between agencies
Please Note: Interpretation of the numbers of children and youth reported as experiencing homelessness should be looked at with consideration. The number may be much greater in some areas than what was reported due to the difference in the definition of homelessness being used by different entities in the identification process.

Homelessness continues to be an issue in North Dakota. The state lacks sufficient affordable housing, especially for low and extremely low-income brackets. The availability of housing options that serve people with differing levels of need is much more limited. In North Dakota there is a willingness to tolerate chronic homelessness as an “acceptable” situation. In part, this belief is fostered by people’s lack of direct experience with chronically homeless individuals. It is difficult to feel a sense of urgency about an issue with which one has little knowledge or first hand experience. The people of this state have a fundamental belief in “self-sufficiency.” This belief often leads people to believe that the chronically homeless do not deserve help because they are not working hard enough to help themselves. Again, the belief itself is an obstacle to building support for the creation of housing options that specifically serve this population. At times, consumers have difficulty accessing available housing resources because of poor rental and credit histories and criminal backgrounds. In addition, very low or no income and an inability to afford rent, whether it is because they are unable to find a job where the pay is sufficient to cover housing costs or because they are unable to keep a job because of a disability.

The most recent formal needs assessment (2004) noted that approximately one of every four homeless individuals is below the age of 17 in North Dakota. A U.S. household sample of nearly 6,500 youth, ages 12 to 17 -- as part of the Youth Risk Behavior Survey (YRBS) -- found that approximately 7.6 percent had been homeless for at least one night during the past 12 months (Ringwalt, C. L., Greene, J. M., Robertson, M., & McPheeters, M. (1998). The prevalence of homelessness among adolescents in the United States. American *Journal of Public Health, 88*, 1325-1329.). This would translate into approximately 1.6 million homeless youth each year nationwide or as high as 12,741 youth in North Dakota.

The most recent Point-In-Time Survey found 1,126 homeless persons in North Dakota including 787 adults, 300 children and 39 persons for whom age was unknown. Of these, 277 people or 24% were long-term homeless. Forty-five percent of individuals noted a history of substance abuse while 35% indicated mental health issues. The following chart provides a regional breakdown of Point-In-Time Survey results.

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Total - ND	787	300	39	1126	64	277	329	512

The North Dakota Coalition for Homeless People, Inc. is the lead entity in the state working to decrease homelessness in North Dakota. Comprised of over sixty organizations (including the North Dakota Department of Human Services), the Coalition is committed to reducing the incidence of homelessness in North Dakota communities, assisting homeless individuals and families to move to self-sufficiency and permanent housing as quickly as possible, and ending chronic homelessness in North Dakota. The Coalition is also the lead entity for the statewide Continuum of Care process.

Through the Continuum of Care process, North Dakota received just over $1.3 million to fund housing and homeless assistance projects throughout the state. These include:

- Ruth Meiers Hospitality House - $119,998
- Fargo Housing & Redevelopment Authority - Shelter Plus Care $188,460
- Share House Inc. - Permanent Supportive Housing $150,000
- YWCA Cass Clay - Transitional Housing $441,365
- Prairie Harvest Human Services Foundation - $85,000
- Abused Adult Resource Center - $78,682
- Society of St. Vincent de Paul - Transitional Housing $15,277

- Community Violence Intervention Center - Transitional Housing $94,772
- Women's Alliance, Inc. Domestic Violence and Rape Crisis Center - Transitional Housing $37,600
- ND Department of Commerce, Division of Community Services - Homeless Management Information System $124,248

In addition to these projects, partnerships between local stakeholders have increased housing options for individuals diagnosed with serious mental illness in many regions. For instance, North Central Human Service Center, in partnership with other public and private stakeholders, is developing Harmony Heights, a four-apartment housing program located above the psychosocial rehabilitation center in Minot. With a case manager located on site, residents will have greater access to services, helping them remain in the community.

The Housing Alliance of North Dakota (HAND) presented "An Address for All" planning conference on Friday, July 24, 2010. Organizers invited a broad group of stakeholders to tackle the challenge of providing affordable, accessible, and safe housing options for all North Dakotans. HAND's goal is to bring housing advocates, service providers and other interested parties to the table to develop a plan to address North Dakota's housing shortfalls. Featured speakers included Marie Williams from Tennessee's Department of Mental Health and Developmental Disabilities who shared that state's successful strategies, and Patricia Tucker, a supported housing expert. Conference attendees took part in guided discussions that will frame what North Dakota wants to do with solutions happening at the local level. The event was sponsored by the North Dakota Department of Human Services' Money Follows the Person initiative and its Division of Mental Health and Substance Abuse Services, the North Dakota Housing Finance Agency, and the North Dakota Center for Persons with Disabilities at Minot State University.

A number of workgroups were organized after the first planning conference. Those workgroups address issues related to legislation and policy, advocacy, and strategic planning for HAND. A steering committee and board of directors has been established with regular meetings being held. HAND continues to serve as a grass roots organization in ND with a focus on ensuring safe, decent, affordable, and accessible housing for all citizens in ND. In October 2010, HAND sponsored "An Address for All-Two" conference. The goal of this second conference was to address housing issues and solutions across the state. Attendees included legislators, service providers, housing specialists, and representatives from financial institutions.

HAND was instrumental in drafting legislation that passed the 2011 Legislative Assembly to create a housing incentive fund in ND.

The past few years have been pivotal for engaging both local and state elected officials in the work toward the goal of ending chronic homelessness. The Governor of North Dakota met with Coalition members in August 2004 to discuss developing a 10-year plan for ending chronic homelessness. Working with Coalition members, the Governor committed to having a plan in place and -- by Executive Order -- established a 19-member North Dakota Interagency Council on Homelessness (NDICH) to develop the plan. The NDICH reports to the Governor and the North Dakota Legislature, which assembles biannually. In addition to state agency directors and NDC members, elected officials included on the NDICH are Dr. Wayne Sanstead, Superintendent of Public Instruction and Mayors Warford, Walaker, and Brown of the cities of Bismarck, Fargo, and Grand Forks respectively. Ten-year plans have been developed or the cities of Bismarck, Fargo, Grand Forks, Minot, Jamestown, Williston, Dickinson, and Devils

Lake. In addition, the Three Affiliated Tribes and the Turtle Mountain Band of Chippewa Indians have each developed 10-year plans.

TREATMENT OF PROBLEM GAMBLING

Treatment for the problem gambler and their family is provided via contract with Gamblers Choice a program of Lutheran Social Services of North Dakota.

Funding for the treatment program is allocated by the North Dakota Legislature utilizing state general funds and proceeds from the state lottery.
Services offered the problem gambler and their family members are provided by nationally certified counselors a requirement of the contract. Services are available in six of the larger cities in the state.

A media campaign to raise public awareness of problem gambling and provide information on available resources is ongoing.

THE NORTH DAKOTA SUBSTANCE ABUSE PREVENTION SYSTEM

OVERVIEW OF SYSTEM

The Department of Human Services' Division of Mental Health and Substance Abuse Services functions as the Single State Agency for Substance Abuse Services, which oversees the statewide substance abuse prevention system.

North Dakota Substance Abuse Prevention system consists of a State technical assistance team, local Targeted Communities program, Prevention Resource and Media Center, and local prevention coordinators on each of the four federally recognized Native American Reservations in North Dakota. The Strategic Prevention Framework is the basis for all state and local community work. As the public health approach suggests, the North Dakota Substance Abuse Prevention system focuses on environmental changes. Because of the highly rural and frontier nature of North Dakota there is a history of minimal active coalitions across the state. Subsequently, a State-level technical assistance team was created to provide specialized services to local communities.

The Division provides local level substance abuse prevention services through a Targeted Communities program. North Dakota communities will have access to targeted substance abuse prevention services at the local level that will be guided by Community Prevention Specialists. Local North Dakota communities are able to apply to become a Targeted Community, where Community Prevention Specialists will provide technical assistance and support in implementing the Strategic Prevention Framework. Targeted Communities will receive guidance assessing data, identifying goals, implementing effective and culturally appropriate strategies and evaluating community progress with a focus on sustainable, environmental efforts. Targeted Communities will also receive additional technical assistance as needed by Prevention Specialists with focuses in particular areas such as education, criminal justice, law enforcement, workplace wellness, and media. There are currently five Targeted Communities being served encompassing both rural and urban communities across the state.

Prevention Specialists in media, workplace wellness, education, and criminal justice will be available to provide specialized services to local communities and tribes across the state, with a

focus in the Targeted Communities. The Prevention Criminal Justice Specialist identifies effective enforcement strategies and provides training and technical assistance regarding substance abuse prevention strategies to local, state, and tribal criminal justice entities. The Prevention Education Specialist provides technical assistance to local educational entities regarding policies, best practices, evidence-based programming and strategies that are developmentally appropriate. The Prevention Media Specialist provides technical assistance to local communities regarding utilizing the media in prevention efforts. This position is also responsible for the development of counter-messaging and media advocacy efforts statewide. The Prevention Worksite Wellness Specialist provides technical assistance to local businesses regarding the implementation of evidence-based policies and programs targeting alcohol and other drug abuse in the workplace.

The Prevention Resource and Media Center (PRMC) focuses on technology, evidence-based prevention strategies, marketing, mass communication, and as a user friendly media resource center/clearinghouse for the citizens of North Dakota. The PRMC also develops materials and tools to assist local communities in implementing effective prevention, such as environmental strategies. The mission of the PRMC is to increase community awareness of substance abuse prevention and increase awareness of effective prevention strategies by providing innovative, quality, and culturally appropriate information to the residents of North Dakota. All PRMC materials are available through the State Library electronic system, accessed online, in person, by e-mail, or by phone. The PRMC e-newsletter provides recent data, news releases, research, new resources, and upcoming events to a list serve. PRMC personnel attend state conferences providing information such as brochures and handouts. PRMC also provides prevention/information materials to regional human service centers.

Science-based prevention has been identified as following a process of strategic planning that focuses on integrating thoughtful assessment, design, implementation, and evaluation into every program. The North Dakota Substance Abuse Prevention system utilizes the Strategic Prevention Framework to guide the selection and implementation of evidence-based prevention strategies by assessing data, ensuring capacity, and consistent evaluation. Current research on effective prevention strategies supports the focus on implementing environmental strategies. Through the N.D. Substance Abuse Prevention Targeted Communities program, Community Prevention Specialists assist local communities in selecting, implementing, and evaluating culturally appropriate environmental strategies based on assessment of local data. Also, statewide prevention efforts include social marketing and media efforts to counteract pervasive social norms. Statewide and local efforts are also focused on ensuring adequate enforcement of substance-related laws and limiting access to substances.

ENTITIES ASSISTING IN SUBSTANCE ABUSE PREVENTION SERVICE DELIVERY

The Governor's Prevention Advisory Council (GPAC) on Drugs and Alcohol was created by Executive Order 2007-03 in May 2007 and is chaired by the Single State Authority for Substance Abuse Services. The Council recognizes that preventative behavior reduces adverse personal, social, health and economic consequences resulting from destructive decisions and that prevention efforts foster safe and healthy environments for individuals, families and communities in North Dakota. The GPAC is the advisory group for the North Dakota SPF-SIG grant. The following agencies/organizations are represented on the GPAC: community advocacy groups, substance abuse treatment, youth organization, University System, Department of Human Services, Department of Health, Department of Transportation, and the Governor’s Office.

The Council is charged with the task of advancing and coordinating knowledge which will result in the adoption of policy-based prevention strategies and innovations and share knowledge of healthy behaviors and decisions that reduce, postpone or eliminate the problems resulting from destructive decisions.

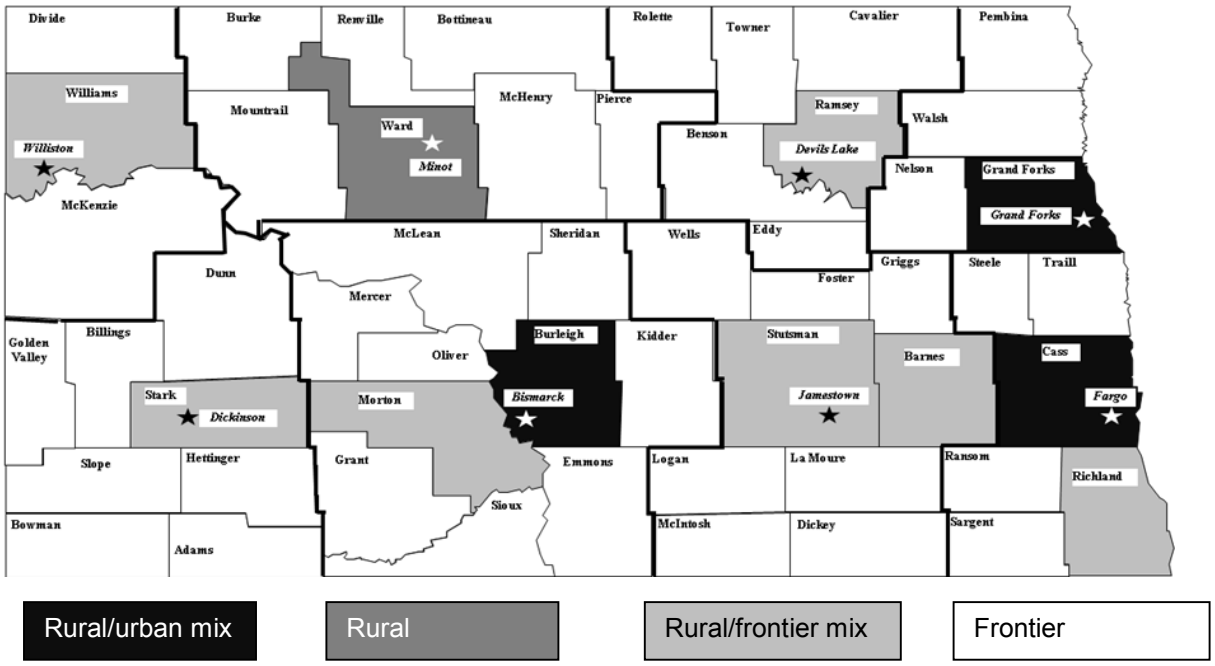
The Council is further charged with a) exploring the interrelationship between substance abuse prevention, education, and enforcement programs; b) addressing traffic safety issues including driving under the influence of drugs and/or alcohol; and c) developing policies that promote safe, stable families and communities.

The Council uses a small granting program to move funding to local communities. Recent efforts developed a website which services as a hub to link all state agencies involved in prevention efforts. The Council members worked with the Division to complete the STOP Act Survey.

TARGET POPULATIONS

Services provided by the North Dakota Substance Abuse Prevention system are data-driven and target those affected most by substance abuse issues; therefore, all residents of North Dakota may be impacted by funded services and activities. According to ND data – all age groups are considered high risk for alcohol use and/or binge alcohol use (ND is #1 in binge drinking for those age 12 and older; NSDUH, 2008), and there are no major gender, racial, or ethnic differences. Therefore, our state work plan identifies strategies targeting all age groups throughout North Dakota. Specific efforts and messages will be tailored to best reach the various populations in North Dakota in order to make an impact.

One-fifth of the nation's populace lives in rural areas making rural residents a sizeable minority groupi. As of 2009, North Dakota had 9 people per square mile compared to the United States at 87 people per square mile. Below is a map illustrating the population density of the state.



According to the U.S. Census Bureau, 91.6% of the state's population is white, 5.4% is American Indian/Alaska Native, and 1.9% is of Hispanic/Latino origin (2007). American Indians represent the largest minority population in North Dakota. Census data estimates indicate that the American Indian population (race alone or in combination) in North Dakota has increased 12 percent from 35,228 in 2000 to 39,525 in 2008.

Local substance abuse prevention funding is distributed to the four federally recognized Native American Reservations, which have been identified as high risk (which accounts for only 3.5% of North Dakota's population, 2000 Census). There is a Tribal Prevention Coordinator in each of the four Native American Reservation in the state. The Tribal Prevention Coordinators provide culturally appropriate technical assistance and assist in implementing evidence-based substance abuse prevention strategies. Tribal regions will also receive additional technical assistance as needed by Prevention Specialists with focuses in particular areas such as education, criminal justice, law enforcement, workplace wellness, and media.

In addition, North Dakota has two Air Force bases, a booming economy based on oil production in the west, and large National Guard population serving at home and abroad. Prevention services will be tailored to meet the needs and risks of the previously mentioned populations.

SUPPORT FUNCTIONS

State and Regional Review Teams

When barriers are encountered while attempting to meet the needs of children and adults who present with unique and complex needs, the Division of Mental Health and Substance Abuse will facilitate the use of the Regional Review Teams and/or State Review Team processes.

The Regional Review Team is a team of administrators representing multiple systems, serving as a resource to local teams by assuring active consideration and utilization of all available state- wide community options & resources when assisting the local team with planning for individuals with complex needs. The Regional Review Team shares knowledge of available

resources, engages in problem solving, provides recommendations, and assists with access to difficult to obtain resources.
If the barrier is not overcome at the regional level, the situation is referred to the State Review Team for response.

The State Review Team is a team of administrators representing multiple systems, available to assist Regional Review Teams with situations where all available options have been exhausted, yet the consumer continues to have unmet needs. The State Review Team meets on a monthly basis and attempts to address the barriers and gaps brought forward by the Regional Review Team, through creative problem solving and braiding together possible options.

The State Review Team is not a forum to resolve disputes or appeal system decisions or replace agency and/or system responsibilities.

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[i] Pruitt, Lisa R. (2009, March 22). The forgotten fifth: rural youth and substance abuse *The Free Library*. (2009). Retrieved August 17, 2011 from http://www.thefreelibrary.com/The forgotten fifth: rural youth and substance abuse.(Symposium: Drug...-a0202203358

II: Planning Steps

Step 2: Identify the unmet service needs and critical gaps within the current system

Page 22 of the Application Guidance

Narrative Question:

This step should identify the data sources used to identify the needs and gaps of the populations relevant to each Block Grant within the State's behavioral health care system, especially for those required populations described in this document and other populations identified by the State as a priority.

The State's priorities and goals must be supported by a data driven process. This could include data and information that are available through the State's unique data system (including community level data) as well as SAMHSA's data set including, but not limited to, the National Survey on Drug Use and Health, the Treatment Episode Data Set, and the National Facilities Surveys on Drug Abuse and Mental Health Services. Those States that have a State Epidemiological Outcomes Workgroup (SEOW) must describe its composition and contribution to the process for primary prevention and treatment planning. States should also continue to use the prevalence formulas for adults with serious mental illness and children with serious emotional disturbances that have been historically reported. States should use the prevalence estimates, epidemiological analyses and profiles to establish substance abuse prevention, mental health promotion, and substance abuse treatment goals at the State level. In addition, States should obtain and include in their data sources information from other State agencies that provide or purchase behavioral health services. This will allow States to have a more comprehensive approach to identifying the number of individuals that are receiving behavioral health services and the services they are receiving.

In addition to in-state data, SAMHSA has identified several other data sets that are available by State through various Federal agencies such as the Center for Medicaid and Medicare Services or the Agency for Health Research and Quality. States should use these data when developing their needs assessment. If the State needs assistance with data sources or other planning information, please contact planningdata@samhsa.hhs.gov.

Footnotes:

UNMET NEEDS AND CRITICAL GAPS

GAPS IDENTIFIED BY NORTH DAKOTA MENTAL HEALTH PLANNING COUNCIL

Prevention:

- Lack a formal comprehensive plan for mental health promotion and mental illness prevention.
- Lack formal connections with existing service providers.
- Shortage of mental health providers.

Military Families:

- Screening and follow-up needs to occur for all soldiers pre-deployment, during deployment, and post-deployment.
- Expand the use of telemedicine to reach more military families.

Trauma and Justice:

- Lack consistent trauma screening at all entry points and throughout the life cycle.

Recovery Support Needs:

- Stigma remains.
- Lack of equity between traditional mental health professionals and peer support workers.

Public Awareness and Support:

- Need more social inclusion campaigns.
- The public's understanding of mental illness is lacking.

SEOW COMPOSITION AND CONTRIBUTION TO PREVENTION PLANNING

The State Epidemiological Outcomes Workgroup (SEOW) was initiated in 2006 by the North Dakota Department of Human Services, Division of Mental Health and Substance Abuse Services. Funding for the project was provided by the Federal Substance Abuse and Mental Health Services Administration (SAMHSA). The mission of the North Dakota SEOW is to utilize relevant state, tribal, and local data to guide substance use prevention planning, programming and evaluation.

The functions of the SEOW are defined as follows:

- Systematically analyze the causes and consequences of the usage of Alcohol, Tobacco, and Other Drugs (ATOD) in order to effectively and efficiently utilize prevention resources.
- Promote decision making based on reliable data throughout the State substance use prevention system.
- Facilitate interagency and community collaboration.
- Provide a mechanism for exchange, access, and utilization of data across organizations related to substance use and consequences.

The North Dakota SEOW, guided by a 44-member advisory committee or workgroup, collects and analyzes data to support a framework for advancing the North Dakota Substance Use and Abuse Prevention System's mission. The following agencies/organizations are represented:

- Native American Tribal representatives from all four federally-recognized Native American reservations.
- Non-profit organizations
- Northern Lights SADD
- Department of Human Services
- Department of Health
- Department of Transportation
- Highway Patrol
- Office of the Attorney General
- Information Technology Department
- North Dakota State University (NDSU) Extension
- Department of Public Instruction
- North Dakota University System
- Office of the State Tax Commissioner
- Department of Correction and Rehabilitation

The initial work of the SEOW was to identify data constructs and indicators to include in an Epidemiological Profile. The SEOW epidemiology team:

- Created a scoring/rating scheme for use by committee members for assessing the validity, reliability, appropriateness, utility, and quality of constructs and indicators. Specifically, questionnaires were used to have workgroup members assign scores ranging from 1 (low quality/appropriateness) to 3 (high quality/appropriateness) to each considered construct and indicator as individuals;
- Discussed and rated the constructs and indicators by breaking into smaller groups on the same scale as a subgroup. Following the subgroup discussion, items that received low scores were discussed in the large group. Also, items that were not included on the list and possible sources for the information were discussed and documented; and
- Collected and processed scores following the meeting and produced mean rating scores that were used to prioritize the items for inclusion or exclusion. Indicators with low mean rating scores (below 1.51) were omitted from consideration. Items with high ratings (2.5 and higher) were accepted for inclusion into the Epidemiological Profile, provided the data were available and accessible to the epidemiological team. Items with moderate ratings (1.51-2.49) we re-examined by the group for availability of data and whether the items clarified or provided information not otherwise available.

Data sources used in the North Dakota Alcohol, Tobacco, and Other Drug Epidemiology Profile development include:

- Youth Risk Behavioral Survey (YRBS)
- Behavioral Risk Factor Surveillance System (BRFSS)
- National Survey on Drug Use and Health (NSDUH)
- North Dakota Core Alcohol and Drug Survey (NDCORE)
- CDC Wonder Query System
- North Dakota Division of Vital Records (NDDVR)
- North Dakota Division of Tobacco Prevention and Control (NDDTPC)
- North Dakota Office of Attorney General (Bureau of Criminal Investigation; NDBCI)
- North Dakota Division of Cancer Prevention and Control (NDDCPC)

- North Dakota Department of Transportation (NDDOT)
- Fatal Analysis Reporting System (FARS), National Center for Vital Statistics (NCVS)
- Treatment Episode Data Set (TEDS)
- North Dakota Department of Corrections and Rehabilitation (NDDOCR).

After consumption/consequence items were prioritized, data were collected and presented to the workgroup graphically in Microsoft PowerPoint slide format at the monthly SEOW meetings. SEOW members gave feedback on grouping of figures and tables with data, format, and clarification in the presentation of data.

The data, summarized in the Epidemiological Profile, characterizes consumption patterns and consequences of various substances in the state of North Dakota. These substances include alcohol, tobacco, and other drugs such as methamphetamines, marijuana and prescription drugs. The latest North Dakota Epidemiological Profile is available on the state's prevention Web site: http://www.nd.gov/dhs/services/mentalhealth/prevention/pdf/2010-epi-profile.pdf.

The data used in Epidemiological Profile are at the aggregate state level, with limited sub-state analyses. A major challenge for the North Dakota SEOW is the limited availability of reliable and valid data at the local level. Limitation in the utility, reliability, and validity of data exist because of the state's small population. The challenge is even greater when considering epidemiological data from sub-state entities, such as counties and school districts.

A recent success in North Dakota has been the completion of a statewide community readiness survey identifying the states readiness to act and the completion, in collaboration with Tribal Councils, of tribal community readiness survey in all four federally recognized Native American reservations in North Dakota.

DATA DRIVEN PROCESS FOR PREVENTION PLANNING

Through work with the SEOW and the North Dakota Substance Abuse Prevention system, two priorities have been developed that guide substance abuse prevention efforts throughout the state. The data sources that are used to identify the needs and gaps of populations mirror those used in the SEOW's Epidemiological Profile with the addiction of the 2008 North Dakota Community Readiness Survey. The two priorities are detailed below.

1. Underage Drinking/Binge Drinking Among Adults

Consumption

Nationally, about half (51.8 percent) of Americans aged 12 or older in 2008-2009 reported using alcohol in the past month, compared to 57.8 percent of North Dakotans (NSDUH). Past month use of alcohol among persons aged 12 to 20 in 2008-2009 (underage use of alcohol) for North Dakotans was 36.5 percent (26.8 percent U.S.). Among North Dakota middle school students, 5.8 percent had their first drink of alcohol at 8 years of age or younger (YRBS, 2009).

The National Survey of Drug Use and Health (2008-2009) found that recent alcohol consumption among North Dakotans ages 18 to 25 is the highest in the nation (75.6% N.D.; 61.2% U.S.). Among North Dakotans aged 26 or older, 60.8 percent (54.4 percent U.S.) had one or more drinks of alcohol in the past month.

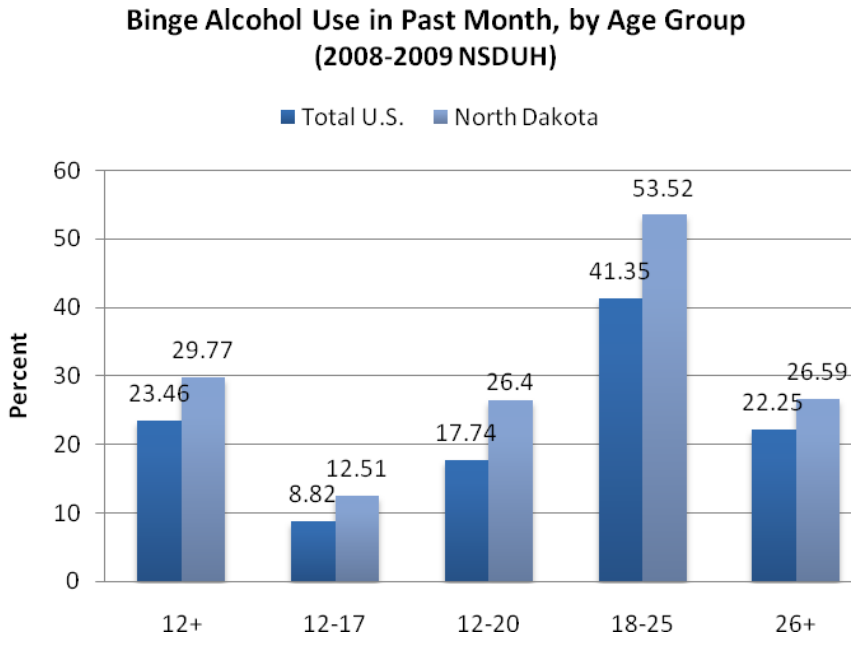
North Dakota is at the 80-90th percentile among U.S. states for alcohol sales (NIAAA, 2009). Per capita alcohol sales by alcohol type indicate that North Dakotans (aged 14 and older) consume beer and spirits at higher rates than the U.S., but lower rates for wine (NIAAA, 2007).

High Risk Consumption

In 2008-2009, almost a quarter (23.5 percent) of persons aged 12 or older in the United States participated in binge drinking in the past month, with North Dakota having the highest rate at 29.8 percent. North Dakota did show a decrease in binge drinking rates between 2007-2008 and 2008-2009 among persons aged 12 or older (from 32.6 to 29.8 percent).

North Dakota had the highest rate for binge alcohol use among persons ages 12-20 (26.4 percent, compared to 17.7 percent nationally). Among high school students, those in North Dakota (30.7 percent) are more likely than those nationwide (24.2%) to have five or more drinks of alcohol is a row within a couple of hours on at least one day within the past 30 days of the survey (YRBS, 2009).

Among 18-25 year old North Dakotans, 53.5 percent reported binge drinking in the past month, compared to 41.4 percent nationwide (NSDUH, 2008-2009). According to the ND CORE Survey, 50.5% of ND College students report binge drinking (2008). Among those 26 years old and above, 26.6 percent (ND) reported binge drinking in the past month, compared to 22.3 percent nationwide (NSDUH, 2008-2009).

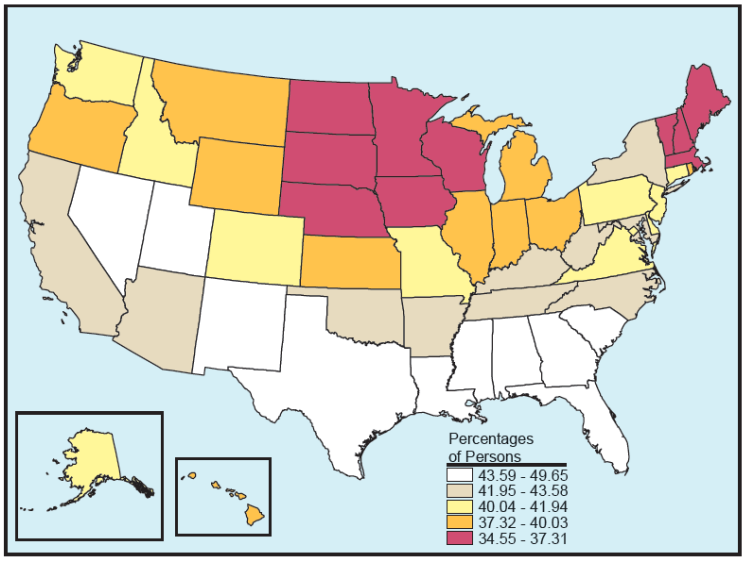


Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2008 and 2009

Perceived Risk

North Dakota is among five states with the lowest perceived risk of binge drinking for the population aged 12 or older (Iowa, Minnesota, North Dakota, South Dakota, and Wisconsin).

***Perceptions of Great Risk of Having Five or More Drinks of an Alcoholic Beverage Once or Twice a Week among Persons Aged 12 or Older,* by State: Percentages, Annual Averages Based on 2008 and 2009 NSDUHs**



Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2008 and 2009

Consequences

In 2008-2009, 7.4 percent of the population aged 12 or older was classified with dependence on or abuse of alcohol nationwide in the past year, compared to 8.4 percent of North Dakotans. Persons aged 18-25 had the highest rate of alcohol dependence or abuse (16.6 percent) in the Nation, with North Dakotans at 20.6 percent. North Dakota is in the top fifth of states for needing but not receiving treatment for alcohol problems among persons aged 12 or older in 2008-2009 (NSDUH).

Over half of all adult arrests (51%) are alcohol and drug related and a quarter of all adult arrests (25%) in the state are DUIs (NDUCR, 2009). Since 2000, the number of alcohol/drug-related prison admissions in North Dakota rose from 252 to 352 in 2009, an increase of 40 percent (NDDOCR, 2009).

Almost half (41%) of fatal crashes in the state are alcohol-related (NDDOT, 2009). Almost one in five (17.8%) of impaired drivers involved in an alcohol-related fatal crash were underage (NDDOT, 2009). North Dakota high school students are more likely than those nationwide to have drove in a car or vehicle when drinking alcohol one or more times in the past 30 days (15.2% and 9.7% respectively; YRBS, 2009).

From 1999 through 2006, North Dakota had an average of 69 liver disease deaths per year. The state's age-adjusted liver disease death rate increased from 9.4 deaths per 100,000 in 1999 to 11.6 deaths per 100,000 in 2005. In 2006, the rate dropped to 8.7 deaths per 100,000 population. The U.S. liver disease death rate has remained stable over the time period at about 12 deaths per 100,000 population (CDC Wonder, 2010; ICD-10 Codes K70-76).

Underage drinking costs the citizens of North Dakota $141 million (PIRE, 2009).

2. Statewide Readiness to Act/ Awareness of Substance Abuse Issues

North Dakota completed a statewide Community Readiness Survey in 2008 determining the state's readiness to act. Understanding the level of community readiness is a vital first step in developing an effective strategy for change and action regarding substance abuse. The five pertinent areas that were addressed in the survey were: 1) Community perception of an ATOD problem; 2) Permissiveness of attitudes towards ATOD use; 3) Community support for ATOD prevention; 4) Community perception of youth access to alcohol and other illegal substances; and 5) Overall perception of community commitment.

Community perception of an ATOD problem

When North Dakota community members were asked to rank the seriousness of adult use of alcohol, 23.2 percent felt this was a serious problem, 65.2 percent indicated this to be a minor-moderate problem in their community, and 5.4 percent indicated this was not a problem in the community. Alcohol use by youth was considered to be more of a problem with 45.3 percent of the community members perceiving this as a minor to moderate problem and 41.3 percent felt this was a serious problem within their community.

Youth and Adult use of marijuana (39.6 percent; 41.8 percent) was perceived as a minor to moderate problem in their community or community members indicated they do not know the extent of the problem (31.3 percent; 34 percent). Regarding use/abuse of other drugs (cocaine, inhalants, hallucinogens, over-the-counter drug, and prescription drugs), North Dakota community members indicated they do not know the extent of the problem among youth and adults (range of 39.7 percent to 54.5 percent). Regarding the use of methamphetamine by adults, 32.9 percent of the Community Members reported this to be a minor to moderate problem, 24.4 percent felt this was a serious problem, and 31.1 percent indicated that they do not know the extent of the problem, which is similar to perceptions of youth methamphetamine use (33 percent, 22.8 percent, and 32.5 percent respectively).

When respondents were asked to indicate their beliefs regarding the contribution of drugs/alcohol to injuries, 49.9 percent of the community members believed that this was a minor to moderate problem, while 34.7 percent felt this was a serious problem within their community. Regarding the contribution of drugs/alcohol to crime, 43.8 percent believed that this was a minor to moderate problem, while 35.7 percent felt this was a serious problem within their community.

Permissiveness of attitudes towards ATOD use

The majority of North Dakota community members disagreed or strongly disagreed (68.4 percent) that underage drinking is acceptable within their community, while 30.7 percent of respondents agreed or strongly agreed that underage drinking is tolerated.

Community perception of youth access to alcohol and other illegal substances

When the North Dakota community members were asked "how difficult is it for youth to get an older person to buy alcohol for them," 48.7 percent believed that it is slightly/somewhat difficult, 40.1 percent indicated it was not at all difficult, and only 7.6 percent believed this be quite/extremely difficult. When the community members were asked "how difficult is it for youth to sneak alcohol from their home or a friend's home," 51.7 percent reported that this was not at all difficult and 39.7 percent perceived this to be slightly/somewhat difficult.

Among North Dakota community members, 28.7 percent responded that youth access to inhalants was not at all difficult; 33.3 percent responded that youth access to marijuana was not at all difficult; 24.1 percent responded that youth access to methamphetamine was not at all difficult.

Community support for ATOD prevention

Of those surveyed, 92 percent of North Dakota community members believe it is possible to reduce alcohol and drug problems through prevention. The majority of (93 percent) of ND community members surveyed believe that alcohol and other drug prevention programs are a good investment because they save lives and money.

Overall perception of community commitment

The majority (79.3%) of North Dakota community members are concerned about whether their community has sufficient alcohol and other drug abuse prevention programs and indicate that there are leaders in their community who are interested in reducing access and abuse of alcohol and other drugs (81.9 percent).

For North Dakota community members, 22.1 percent responded that "Yes" they do have a community action plan in place, 15.4 percent specified that "No" there was not a plan in place, and 60.1 percent of respondents "Did Not Know" if their community had any action plan in place.

Summary

A community's level of readiness can limit effective prevention efforts. For example, with low awareness it is difficult to implement effective strategies such as policy change. In order to make policy or law changes it is necessary for community leaders to have community support or buy in. If nothing is wrong, why make changes? The North Dakota Statewide Community Readiness Survey indicates that community members are not aware of the substance abuse issues and are not aware of the consequences relating to substance use. Also indicated was a high level of perceived access for youth, especially to alcohol. When assessing the data available on substance use, abuse, and consequences, the SEOW and North Dakota Substance Abuse Prevention system identified a need to increase awareness among North Dakota community members in order to move toward positive change.

GAPS AND UNMET NEEDS – SUBSTANCE ABUSE PREVENTION SYSTEM

The North Dakota Substance Abuse Prevention system has interweaved the Strategic Prevention Framework within the work of the SAPT BG in recent years to create a system that is data-driven, with a focus on effective prevention strategies, cultural competence, and sustainability. The N.D. Substance Abuse Prevention system's strategic plan outlines four key areas of focus: 1) Access; 2) Workforce; 3) Quality; and 4) Efficiency. How the prevention system plans to sustain infrastructure and positive outcomes are delineated within these four broad categories.

Access

In order to ensure those in highest need are receiving the most targeted services, the N.D. prevention system continually collects and reviews relevant substance abuse prevention data, through the state's SEOW, and identifies high risk populations at the state and local levels as available. Following the Strategic Prevention Framework, the data then drives identification of culturally-appropriate and sustainable evidence-based prevention strategies to be implemented. These strategies are brought to the local-level through the N.D. Substance Abuse Prevention Technical Assistance Team. Strategies are monitored through process and outcome evaluation.

As North Dakota is a mostly rural/frontier state, local coalitions historically have not become sustainable. In working with this barrier, the North Dakota Substance Abuse Prevention system has shifted focus to providing specialized technical assistance regarding the Strategic Prevention Framework and effective prevention strategies to local community members, key leaders and local organizations. This focus ensures that local communities throughout the

state, even if they are unable to maintain an active coalition, have the opportunity to enhance their capacity to address substance abuse. Technical assistance and the state-wide prevention efforts are delivered through multiple channels such as the media, communities, schools, law enforcement entities, government, and public agencies.

Certain populations that are hard-to-reach, including the transient population in the western half of the state because of the oil boom and the LGBTQI population. The military population is involved in prevention efforts and partnerships have been made with local Drug Demand Reduction officers. Prevention funding is distributed to the four federally recognized Native American Reservations, which have been identified as high risk (which accounts for only 3.5% of North Dakota's population, 2000 Census). There is a Tribal Prevention Coordinator in each of the four Native American Reservation in the state. There are also many links between mental illness and substance abuse that remain unknown, such as depression, suicide, and traumatic brain injury. There are limited services to children and families of those with mental illness and substance use disorders.

As the public health model describes, there is a range of prevention from primary to tertiary. As the SAPT BG requires, the focus of the N.D. Substance Abuse Prevention System is on primary prevention, so there is a gap in the state regarding secondary/tertiary prevention (intervention).

Workforce

There is no accredited prevention or public health education program in the state; therefore, a gap exists in prevention workforce. The Division provides Substance Abuse Prevention Specialist training and all North Dakota Substance Abuse Prevention staff has completed this training. The state Substance Abuse Prevention Technical Assistance Team aims to lessen this gap by providing trainings and assistance to key partners (law enforcement, key community leaders, etc.) regarding the Strategic Prevention Framework and effective prevention strategies.

Quality

The N.D. prevention system's goal is to provide quality services, and does so by following the Strategic Prevention Framework. Because all efforts and plans are guided by relevant data there is an innate quality in the services provided. Evaluation is a critical component and the prevention system continually evaluates efforts and processes to ensure the highest quality. Also, the collaboration and engagement of several groups, such as the Governor's Prevention Advisory Group and the SEOW, assist the state's prevention system in ensuring effective and quality services are delivered.

Efficiency

In order to ensure an efficient delivery system, the Strategic Prevention Framework is utilized to provide data-driven and outcome-based prevention services by continuously reviewing available data, capacity, cultural competency, and sustainability.

UNMET NEEDS - ADULTS

Based on the needs identified previously, North Dakota is implementing or planning to implement the following:

- There are limited resources for completion of assessments. Because of the challenges of recruiting and retaining clinical staff, workloads at the regional human service centers have increased at times resulting in delays in receiving an assessment.

- The Department is working with various entities to address workforce issues. Rural issues including difficulty recruiting mental health professionals and access issues a concern.
  In the Department, workforce issues are being addressed through the following:

    - Working with each division/location on an individual basis to assess current and future staffing levels, as well as the skills that will be necessary in the future. Meeting with divisions/supervisory staff to emphasize the flexibility that we do have in state government. We have found that this is something that has drawn staff to our agency recently, particularly in terms of working hours.
    - Modifying existing policies and procedures to allow for continued and additional flexibility in work situations. Examples include telecommuting, altered work hours, infant-at-work, job sharing, and recruitment/referral/retention bonuses.
    - Tuition assistance for employees who choose to obtain additional skills and knowledge
    - Assessment of other options, such as non-traditional work hours
    - Surveying individual employees to ascertain what needs they have and what it will take to keep them in the workforce
    - Development of the DHS Leadership Group (help to identify current and future leaders in DHS)
    - Increased out-of-state recruitment: with the positive economy in North Dakota right now, we have had good success in recruiting candidates to come from out-of-state. In several areas of the State we have an interesting problem of being able to attract candidates but then having them not be able to find anywhere to live. This is especially true in Dickinson and Williston, and I suspect will get worse in Minot and Bismarck.
    - Use of interns: DHS has made use of the State Internship Program to employ students who are needing internship/placement credits and are also needing work experience. It's something that the Legislature funded again for the 11-13 biennium and is a program whereby agencies apply and if approved, they can get 100% of the funding from HRMS/OMB. It is available to all parts of the Department and will be mentioned again at the upcoming senior managers meeting.

- There are limited employment opportunities for consumers.

  - The regional human service center staff assigned to the Extended Services and Supported Employment programs work extensively with employers to cultivate new job opportunities for consumers. In all areas of the state, employment opportunities are limited due to geographic location or job market. In Williston – currently experiencing a boom due to oil drilling – the job market is open and good paying positions are fairly easy to come by. Starting salaries are in excess of $9.00 per hour. However, opportunities in rural communities can be at times non-existent. The Division worked with Southeast Human Service Center to implement SAMHSA's evidence-based practice model of Supported Employment in March 2009. The Division will continue to work with the regional human service centers and Vocational Rehabilitation to enhance when possible employment services for consumers statewide.

- Access to psychological and psychiatric services in a timely manner can be challenging in the state. Again, the challenges of recruiting and retaining clinical staff has resulted, at times, in longer waits to receive some clinical services.

- Closing of two private inpatient psychiatric facilities and loss of psychiatric services places a greater strain on the community based systems in Regions I and VIII.

  - The Department of Human Service has implemented telemedicine and telepharmacy services, which has allowed regions with limited or no access to psychiatric time to access the services of a psychiatrist. In addition, the Department of Human Services is in conversation with private psychiatric facilities to develop plans for continued services and, where possible, enhancements and collaboration between public and private providers.

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- Oil boom challenging the human service system due to increased need for mental health and substance abuse services as well as decreased affordable housing available.

  - The Department of Human Services continues to monitor the need for residential options for adults with serious mental illness and those with substance use disorders and works with stakeholders to implement new housing options. During the past biennium, new residential facilities have been opened in the Williston, Fargo, and Jamestown regions through the cooperative efforts of regional stakeholders.

  - The Housing Alliance of North Dakota (HAND) presented "An Address for All" planning conference on July 24, 2009. Organizers invited a broad group of stakeholders to tackle the challenge of providing affordable, accessible, and safe housing options for all North Dakotans. HAND's goal is to bring housing advocates, service providers and other interested parties to the table to develop a plan to address North Dakota's housing shortfalls. Featured speakers included Marie Williams from Tennessee's Department of Mental Health and Developmental Disabilities who shared that state's successful strategies, and Patricia Tucker, a supported housing expert. Conference attendees took part in guided discussions that will frame what North Dakota wants to do with solutions happening at the local level. The event was sponsored by the North Dakota Department of Human Services' Money Follows the Person initiative and Division of Mental Health and Substance Abuse Services, the North Dakota Housing Finance Agency, and the North Dakota Center for Persons with Disabilities at Minot State University.
  - A number of workgroups were organized after the first planning conference. Those workgroups address issues related to legislation and policy, advocacy, and strategic planning for HAND. A steering committee and board of directors has been established with regular meetings being held. HAND continues to serve as a grass roots

organization in ND with a focus on ensuring safe, decent, affordable, and accessible housing for all citizens in ND. In October 2010, HAND sponsored "An Address for All-Two" conference. The goal of this second conference was to address housing issues and solutions across the state. Attendees included legislators, service providers, housing specialists, and representatives from financial institutions. The Alliance is in the process of obtaining a 501 (c)3 status. A brochure to illustrate the housing story of North Dakota has been developed. Emphasis is being placed on increasing membership. A policy platform has been developed for presentation to the decision makers of the state to embrace as the housing policy of North Dakota. The basic premise of the policy platform is one of "housing first". The efforts of the Alliance support the fifth SAMHSA Initiative, Provide housing and reduce the barriers that homeless persons with mental and substance use disorders and their families experience to accessing effective programs that sustain recovery.

- HAND was instrumental in drafting legislation that passed the 2011 Legislative Assembly to create a housing incentive fund in ND.

- There is a need for increased training opportunities for families.

  - A number of training opportunities are offered to families of consumers throughout the state. Often, stipends are made available allowing for free or reduced cost attendance. Some of these opportunities include the annual Family Connections Conference, the Children and Family Services Conference, the Indian Child Welfare Act conference, the North Dakota Family Based Services Conference, and the Clinical Forum on Mental Health Conference.

- Advocacy and support to families.
  - A number of advocacy and support groups exist throughout the state. These include Protection and Advocacy Project, the Federation of Families' Parent-to-Parent Support Program, Mental Health America of North Dakota, NAMI, Family Voices of North Dakota and the North Dakota Consumer and Family Network. The Division will continue to assist these organizations whenever possible.

- Aging/Mental Health: Growing area of service need. Need more resources to help providers.

  - The Division of Mental Health and Substance Abuse Services is focusing attention on the enhancement of mental health services to the aged population throughout the State. During the past year, the Natural Caregiver Program and the Mental Health Clinician Training Program was continued, allowing the Division to further increase the cadre of clinicians and others trained in mental health and aging. A review of assessments indicated that 100% of participants that completed the web-based training demonstrated mastery of the course material by scoring 70% or greater on the knowledge assessments. Also an additional 281 natural caregivers received training on mental health and aging. To date, nearly 40,000 Mental Health and Aging educational materials have been distributed since the project's inception. The

material has been adapted for use by Native American communities and distributed to North Dakota reservations and organizations that serve the Native American communities.

- Guardianship Issues: Need to fund guardianship services for vulnerable adults and elderly. Access is an issue and demand is high.

  - During the 2005 Legislative Session, SB 2028 provided for a guardianship services system for vulnerable adults who are ineligible for developmental disabilities case management services. Forty thousand dollars was appropriated for this system. The Division of Aging Services within the Department of Human Services was tasked with overseeing the implementation of the guardianship services system. Because of the limited funding ($40,000) and the need for such services from this target population, it was planned that twelve adults diagnosed with a serious mental illness would receive guardianship services through this program. A Request for Proposal was drafted for this program and training was conducted for attorneys, judges, and human service center case managers concerning guardianships for vulnerable adults. Unfortunately, there were no responses to the Request For Proposal.

    Due to the lack of RFP responders and to meet the legislative mandate, it was decided that the North Dakota Department of Human Services would pay for adult emergency or full guardianship establishment fees. This includes the attorney's fee, filing fee, and other fees connected with establishing the guardianships. There is no ongoing daily rate of pay. The target population for the program was individuals diagnosed with a serious mental illness, persons with Traumatic Brain Injury or persons over the age of 60. The work with the attorney, families, and proposed guardian is the responsibility of the regional human service centers. The cost for establishing the guardianship cannot exceed $2,500.

    This program continued through the 2009-2011 biennium and utilization has increased. Funding for this biennium is nearly exhausted. For this reason, a budget request was made in the 2011 legislative session and funding increased and added a $500 annual payment to guardians.

- Staff shortages are increasing wait times.
  - The Department is working with various entities to address workforce issues. This program will help provide clinicians to those rural areas where often it is difficult to recruit for. In addition, the Division is working with WICHE to draft a workforce development plan.
  - There is a psychological internship program between West Central Human Service Center and Standing Rock Sioux Tribe.
  - Southeast Human Service Center has become an American Psychological Association intern site.
  - Many human service centers have allowed existing behavioral health professionally trained staff to complete their licensed addiction counseling requirements while employed.

In the Department, workforce issues are being addressed through the following:

- Working with each division/location on an individual basis to assess current and future staffing levels, as well as the skills that will be necessary in the future (results to be shared with each division shortly)
- Meeting with divisions/supervisory staff to emphasize the flexibility that we do have in state government. We have found that this is something that has drawn staff to our agency recently, particularly in terms of working hours.
- Modifying existing policies and procedures to allow for continued and additional flexibility in work situations. Examples include telecommuting, altered work hours, infant-at-work, job sharing, and recruitment/referral/ retention bonuses.
- Tuition assistance for employees who choose to obtain additional skills and knowledge
- Assessment of other options, such as non-traditional work hours
- Surveying individual employees to ascertain what needs they have and what it will take to keep them in the workforce (this is a project that we're working on with Decision Support and will be underway hopefully yet this month)
- Development of the DHS Leadership Group (help to identify current and future leaders in DHS)
- Increased out-of-state recruitment: with the positive economy in North Dakota right now, we have had good success in recruiting candidates to come from out-of-state. In several areas of the State we have an interesting problem of being able to attract candidates but then having them not be able to find anywhere to live. This is especially true in Dickinson and Williston, and I suspect will get worse in Minot and Bismarck.
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- Adults with serious and chronic mental illness need access to more job development and employment services to support their recovery.
  - The regional human service center staff assigned to the Extended Services and Supported Employment programs work extensively with employers to cultivate new job opportunities for consumers. In some areas of the state, employment opportunities are limited due to geographic location or job market. In Williston – currently experiencing a boom due to oil drilling – the job market is open and good paying positions are fairly easy to come by. Starting salaries are in excess of $9.00 per hour. However, opportunities in rural communities can be at times non-existent. The Division worked with Southeast Human Service Center to implement SAMHSA's evidence-based practice model of Supported Employment in March 2009 The Division will continue to work with the regional human service centers and Vocational Rehabilitation to enhance, when possible, employment services for consumers statewide.

- State needs more residential services and housing options for adults with chronic mental illness and adults with substance use disorders.
    - The Department of Human Services continues to monitor the need for residential options for adults with serious mental illness and works with stakeholders to implement new housing options. During the past biennium, new residential facilities have been opened in the Williston, Fargo, and Jamestown regions through the cooperative efforts of regional stakeholders.
        - The Housing Alliance of North Dakota (HAND) presented "An Address for All" planning conference on July 24, 2009. Organizers invited a broad group of stakeholders to tackle the challenge of providing affordable, accessible, and safe housing options for all North Dakotans. HAND's goal is to bring housing advocates, service providers and other interested parties to the table to develop a plan to address North Dakota's housing shortfalls. Featured speakers included Marie Williams from Tennessee's Department of Mental Health and Developmental Disabilities who shared that state's successful strategies, and Patricia Tucker, a supported housing expert. Conference attendees took part in guided discussions that will frame what North Dakota wants to do with solutions happening at the local level. The event was sponsored by the North Dakota Department of Human Services' Money Follows the Person initiative and Division of Mental Health and Substance Abuse Services, the North Dakota Housing Finance Agency, and the North Dakota Center for Persons with Disabilities at Minot State University.
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        - HAND was instrumental in drafting legislation that passed the 2011 Legislative Assembly to create a housing incentive fund in ND.

- Dual diagnosis population needs transition to community services and long-term residential housing and supports.

- Southeast Human Service Center continues to provide Integrated Dual Disorder Treatment (IDDT) programming with consumers diagnosed with mental illness and co-occurring substance abuse disorders. Consumers are served by two teams for those who meet criteria for Quadrant 4. Between the two teams, 80 - 85 consumers are receiving services at any given time. In September of 2010, annual fidelity reviews were conducted. Southeast Human Service Center received an overall rating of 4.2 out of a possible 5 for the services to team 1 and an overall rating of 3.9 for team 2. The action plan will be revised to reflect ongoing work towards continued fidelity-to-model. Staff at Southeast Human Service Center and the Division of Mental Health and Substance Abuse Services continue to work closely with consultants from Ohio SAMI CCOE, Case Western Reserve University, on this project.

- Over the past two years, Division of Mental Health and Substance Abuse Services staff, in close collaboration with staff from Southeast Human Service Center have conducted a number of readiness meetings with a team of staff from South Central Human Service Center to assist in exploring their interest in implementing IDDT programming. Staff have participated in basic IDDT training and a more formalized overview of IDDT conducted by Southeast Human Service Center. A steering committee has been developed, a team lead has been identified, and a group of staff are working on program criteria. Two other regions in the state, West Central and Lake Region, have identified an interest in beginning readiness meetings. A formal meeting including the consultants from Ohio SAMI CCOE was held with a select group of staff from Lake Region Human Service Center in September of 2010. The Division of Mental Health and Substance Abuse Services, in conjunction with a consultant from the Center for Evidence Based Practices at Case Western Reserve University, has scheduled a two day training on IDDT implementation for staff from all eight human service centers and the ND State Hospital for August 29-31, 2011. The goal of the training is to provide information on the implementation of IDDT and provide each regional center and the hospital with the opportunity to discuss/assess their readiness to implement IDDT. Data indicates a significant number of consumers with serious mental illness and co-occurring substance abuse.
- Implementation of an inpatient adaptation of IDDT at the ND State Hospital continues. The first annual fidelity review was conducted by consultants from the Center for Evidence Based Practices at Case Western Reserve University and staff from the Division of Mental Health and Substance Abuse Services in September 2010. Results of the review indicate an overall rating of 3 out of a possible 5. The hospital has updated their action plan based on the results and recommendations of the review to reflect ongoing work towards continued fidelity-to-model. As implementation continues, this level of inpatient programming will greatly enhance continuity of care and transition for consumers who return to their home communities. Staff from Southeast Human Service Center and the hospital work in close collaboration with consumers they currently have in common now. As implementation of the inpatient model progresses, continuity of care will be enhanced.
- In March 2009, a pilot project of the evidence-based practice Supported Employment was implemented into the IDDT program at Southeast Human Service Center. The pilot was a collaborative effort between Vocational Rehabilitation, Southeast Human Service Center, the North Dakota Center for Persons with Disabilities Medicaid Infrastructure Grant, Community Options for Residential and Employment Services,

Inc., and the Division of Mental Health and Substance Abuse Services. The baseline fidelity and two days of training were conducted in April 2009. An action plan was developed based on the results of the review. Community Options for Residential and Employment Services, Inc. is the provider of employment services. They employ an employment team of two employment specialists and a team lead. Each employment specialist provides services to up to 20 consumers at any given time and the team lead provides services to up to 12 consumers at any given time. The employment specialists and team lead are embedded into each IDDT team and a generalist team at Southeast Human Service Center. The annual fidelity review in March of 2010 was conducted by a consultant from the Center for Evidence Based Practices at Case Western Reserve University and staff from the Division of Mental Health and Substance Abuse Services. The results of the review indicated an overall rating of 3.8 out of a possible 5. The action plan was updated to reflect the results and recommendations of the review. The employment services provider relies heavily on the action plan to drive full implementation of the model. The annual review was conducted by staff from the Division of Mental Health and Substance Abuse Services, Vocational Rehabilitation, and Southeast Human Service Center in June of 2011. The results of this review indicated an overall rating of 4.32 out of a possible 5. Results and recommendations of the review will be used to update the action plan and guide the team towards continued fidelity-to-model. A satisfaction survey was distributed to consumers and team members in March of 2011. The results indicated that consumers are satisfied to very satisfied with and appreciate the employment services they receive, jobs group, and tours to job sites. Responses from team members ranged from satisfied to very satisfied as well. We are pleased to report that the budget for supported employment is now included in the overall budget for Southeast Human Service Center for 2011-13. Ongoing assessment will be made about the needs of consumers in other regions of the state.

- Divert people from corrections by training law enforcement personnel and coordinating with behavioral health system.
    - Department is working closely with the Department of Corrections and Rehabilitation to ensure that individuals who have a serious mental illness and are in prison have a smooth transition once they are released. Through the Release and Integration Program, case managers from the human service centers meet with inmates a few months prior to their scheduled parole to begin preliminary work on securing housing and any other needed assistance. The goal of this program is to assist the consumer with transitioning back into the community and – through the establishment of an informal and formal support system – help the consumer avoid re-incarceration.

    - The Department of Human Services worked with Protection and Advocacy, the Department of Corrections and Rehabilitation, and other stakeholders to implement Individual Justice Planning (IJP). For individuals that have or are at risk of coming into contact with the criminal justice system, an IJP can identify the training, services, and support necessary to prevent criminal behavior from re-occurring. The IJP references other treatment or service plans that provide detailed information to effectively provide care. Training for this program has concluded however Individual Justice Plans are being used throughout North Dakota.

- The Department of Human Services worked with Cass County (the Fargo area) during their implementation of a post-booking diversion program. Cass County was awarded a $250,000 grant from the U.S. Department of Justice for planning and implementation of diversion strategies to reduce recidivism, enhance public safety, and improve outcomes for individuals with a primary Axis I diagnosis who come into contact with law enforcement due to symptoms of their serious mental illness. The project is supported by ND Supreme Court Chief Justice Gerald VandeWalle, ND Attorney General Wayne Stenehjem, East Central presiding District Judge Georgia Dawson, and Cass County States Attorney Birch Burdick. The Cass County Sheriff's Office is the lead agency, working collaboratively with Southeast Human Service Center, Judiciary, defense and prosecuting attorneys, and other community partners.

  Phase I of the Project focuses on post-booking diversion, and Phase II addressed pre-booking diversion. Post-booking diversion identifies those with serious mental illness who are booked into the Jail, links individuals to treatment and services, and works to dismiss legal charges when appropriate.

  Availability and accessibility of community-based services, including case management services and integrated treatment for co-occurring chemical dependency, are key to effective diversion programs. The Jail Intervention Coordinating Committee of Cass County worked to identify gaps in processes and service availability.

- Southeast Human Service Center is involved with a collaborative effort with the City of Fargo and other partners. This collaboration has resulted in the development of a long-term housing project. Southeast Human Service Center provides 24-hour staff person and also provides case management services and behavioral health services for many of the individuals in residence.
- Corrections also has membership on the Recovery Council, Mental Health Planning Council, and State Review Team.
- There is an ongoing interim legislative committee – Alternatives to Incarceration – in place. This committee studies needed alternative and brings forward proposed legislation to address this issue.

- Support more peer support services to promote recovery.
  - The Division of Mental Health and Substance Abuse Services and the North Dakota Mental Health Planning Council will continue to support the Protection & Advocacy Project's implementation of mental health advanced directives. The Protection & Advocacy Project (P&A) and its Advisory Council for the Protection & Advocacy of Individuals with Mental Illness (PAIMI) have researched ways to more actively involve individuals with mental illness in their treatment planning. Mental Health Advance Directives (also known as Psychiatric Advance Directives) have been one of the more promising innovations in recent years to give individuals with a severe mental illness a greater voice in their treatment. Mental Health Advance Directives are now widely recognized across the country. A Mental Health Advance Directive is a legal and medical document. Individuals are encouraged to use this tool as a way to inform and collaborate with their treatment providers. The goal is for the individual to receive the treatment most conducive to his or her mental health needs.

- DMHSAS will continue to expand on Peer Support Services throughout the state. In spite of Peer Support Services being implemented in all 8 Regional Recovery Centers in the near future, funding is not adequate to meet the needs of all consumers. Data collection will be important during the next year to measure effectiveness and to provide outcomes to future legislative sessions.

- Permanent housing for individuals with co-occurring mental health and substance abuse disorders based on stages of change model
  - The DHS is represented on the Housing Alliance of North Dakota. Department staff will continue to represent the needs of consumers and work collaboratively with the Alliance to address these needs. The Alliance is an ideal venue for ongoing collaboration with housing stakeholders. Information regarding resources is provided to the Division of Mental Health and Substance Abuse services and regional human service center staff. The Division works closely with the Money Follows the Person Program Administrator and Medical Services Division on housing issues as well. Given the more recent development of a serious housing shortage in western North Dakota, it's become more pressing to address the needs of vulnerable consumers. High increases in rent have forced some individuals out of their homes.
  - DMHSAS staff and system partners will support Prison Release Work Group (PRWG) efforts to secure transitional housing services for prison release when mental health issues are involved.

- There is a need to increase long-term supportive housing as many individuals in transitional living homes across the state have been permanently placed in these institutions.
  - * The DHS is represented on the Housing Alliance of North Dakota. Department staff will continue to represent the needs of consumers and work collaboratively with the Alliance to address these needs. The Alliance is an ideal venue for ongoing collaboration with housing stakeholders. Information regarding resources is provided to the Division of Mental Health and Substance Abuse services and regional human service center staff. The Division works closely with the Money Follows the Person Program Administrator and Medical Services Division on housing issues as well.
  - DMHSAS staff and system partners will support Prison Release Work Group (PRWG) efforts to secure transitional housing services for prison release when mental health issues are involved.

- There is a need to enhancing/expanding community-based options, mobile crisis services, and advanced directives
  - DMHSAS staff and system partners will support implementation of Crisis Intervention Teams (CIT) with the focus on launching the first team in the North Central region, Minot. A Train-the-Trainer model will be supported.
  - DMHSAS staff and system partners will support all jail diversion/post booking efforts in ND

- DMHSAS staff will distribute information on the First Responders Model to those individuals/communities involved in implementing CIT for the purpose of determining if the model “fits with” CIT.
- DMHSAS staff will encourage/support the inclusion of CIT training at the ND Police Academy.
- DMHSAS staff and system partners will support/encourage the development of Individual Justice Planning for all those individuals who meet the criteria.
- DMHSAS staff and system partners will encourage staff at the regional human service centers to explore and develop options for consumers before they need to call 911 and to include these options in the development of treatment plans with consumers.
- DMHSAS staff and system partners will support training of consumers and professionals on Mental Health Advanced Directives or Psychiatric Advanced Directives.
- DMHSAS will encourage regional human service centers and systems partners to expand/enhance current local, community-based efforts/practices in all areas of the state.
- DMHSAS staff will continue to work closely with HSC staff to research evidence-based practices for potential implementation.
- DHS division staff along with systems partners will analyze barriers to the availability of expanding the role of nursing facilities across the state to provide home and community-based services to individuals with serious mental illness.
- DMHSAS staff and system partners will encourage the utilization of existing mobile outreach services to implement mental health screening services in local communities.

- There is a need to enhance the state’s ability to meet the needs of children and adults with complex needs.
  - The State Review Team has been actively addressing this issue for the past year through monthly meetings. Identified goals are to increase the knowledge and skills of case managers and other professionals; increase the ability of Residential Facilities to serve these individuals; ensure individuals are served by the appropriate systems to meet their needs; enhance the assessment/evaluation process through the creation of specialized resource teams; and improve resource and referral through the creation of regional review teams.

- Division staff are working closely with Money Follows the Person (MFP) Program Administrator and Medical Services Division on a project to expand the MFP project in ND. The proposed project would utilize MFP to transition children/youth from psychiatric residential treatment facilities in ND and out of state facilities. In addition, a 1915(i) Medicaid state plan amendment would be written/submitted to CMS.

- In March of 2007, the DHS was awarded a three year Traumatic Brain Injury (TBI) Partnerships Implementation Grant from the Health Resource and Services Administration (HRSA). The goals of the grant were: 1) addresses infrastructure capacity through an advisory committee leading to a formal advisory board; 2) build capacity through a statewide TBI summit and expanding education through existing association conferences and medical education; 3) build capacity through the development of a screening tool process and efforts to address TBI needs of veterans; and 4) build capacity and cultural competence by developing a pilot demonstration program on peer mentoring. The grant supported individuals with TBI, their family members and caregivers, service providers, advocates, and others to work together to build a stronger, more viable service system. A need assessment conducted during the 2003-2005 TBI Planning Grant established four primary themes: 1) sustainability (inclusive of statewide infrastructure and capacity building elements); 2) education and awareness; 3) enhancement of services; and 4) tribal issues. These themes were utilized to establish the goals of the implementation grant are directly related to the findings of the assessment process. The goals of the grant were met. . In 2009, the DHS looked to the TBI advisory committee to make recommendations about the budget planning process regarding TBI services for the 2009-11 biennium. Two separate pieces of legislation related to TBI passed during the 2009 legislative session. The first directed the legislative council, during the 2009-11 interim, to study the impact on the State's human services system provision of services for individuals with traumatic brain injury, including veterans who are returning from wars,. The second law established TBI services to be administered by the Department of Human Services, including informal support services, prevention, and identification efforts; social and recreational services; quality control and training to case managers and other persons providing services to individuals; and the provision of increased and specialized vocational rehabilitation and consultation to individuals who have sustained a TBI for extended support for those individuals at risk of losing their employment upon exhausting their vocational services. This law also established that the Department of Human Services, as the lead agency, would at least annually call a joint meeting of the Adjutant General, the State Department of Health, the Department of Veterans' Affairs, and the Superintendent of Public Instruction to discuss the provision of services to individuals who have sustained a TBI. The Department has decided that these meetings will be held quarterly, instead of annually and will serve as a systems development meetings in conjunction with the continued work of the advisory committee. The Department of Human Services determined that the informal support funds from the 2009 legislation would be best implemented by contracting with the Head Injury Association of North Dakota (HIA). Social and recreational services are provided by HIT, Inc., an agency with years of proven success in meeting the needs of individuals with head injuries. Pre-vocational skills services and mentoring is provided by another agency with years of proven experience in the field of employment services. Funds were increased to provide ongoing employment supports to individuals working with Vocational Rehabilitation. A TBI screening tool was implemented at the eight regional human service centers in March 2011. The screening tool has been integrated into the intake process for all consumers except those who apply for developmental disability services only. The goals of implementing the screening tool are to provide vital information to clinicians to better understand who they are

providing services to, improve treatment outcomes for consumers, and to provide data to DHS to utilize in future service and budget planning. The systems development meetings serve as a venue for open discussions not only about service coordination and collaboration but more importantly about unmet needs of individuals with TBI and their family members. The results of ongoing meetings has the potential to influence ongoing decisions about services and system development.

- Passing of legislation during the 2011 legislative session resulted in additional funding to the DHS to increase informal supports, public education and awareness, and peer mentoring in the eastern part of ND. The Head Injury Association will oversee the provision of these services.

- There is a need for resource facilitation or case management services for individuals who have sustained a TBI. There is also a need for a flexible funding mechanism to purchase specialized services that for whatever reason, are not covered by Medicare, Medicaid, or other insurance. Once such service is substance abuse treatment. Research indicates that at least 50% of individuals with a TBI are at risk to develop or have a substance abuse problem. Conversely, at least 50% of individuals with a substance abuse problem are at risk to sustain or have a TBI. Specialized training for substance abuse providers is a need. The DHS has begun to address this need by sponsoring training sessions for providers at the annual alcohol summit.

- Increased demand for mental health and substance abuse services available in the public system will emerge as military personnel and their families feel more comfortable to seek services and/or exhaust services offered by the VA or other support systems. The ND DHS has participated on the Inter-Service Family Assistance Committee (ISFAC) for the past two years. ISFAC is a multi-agency committee dedicated to collaboration around the needs of military servicemen and women and their families. The ND National Guard, Office of Veterans Affairs and the VA are active participants on the TBI Advisory Committee and TBI Systems Workgroup. Current efforts are underway to collaborate with the Office of Veterans Affairs on a number of issues and projects, including planning of a Veterans Summit for 2012. This collaboration provides the opportunity to stay abreast of all the efforts across the state and to share information about agency resources and services. In past years, a number of training opportunities have been provided to staff on military related issues such as military culture and reintegration. These effort supports the third SAMHSA Initiative for military families with the goal of support of our service men and women and their families and communities by leading efforts to ensure needed behavioral health services and outcomes are successful.

UNMET NEEDS - CHILDREN

Psychiatric Residential Treatment Facilities (PRTF) unmet needs:

1. Placement issues with dual diagnosis (MI/DD) youth.

2. Capacity issues at PRTF

3. State Review Team has started collaboration with Dakota Boys and Girls Ranch, a private facility in Minnesota, and the Developmental Center for placement capacity and staffing to serve this population.

4. The challenge of adequate management of aggressive behavior in various settings.

Treatment Collaborative for Traumatized Youth Unmet Need: In an effort to meet the increasing needs for family therapy that is related to conflict & abuse issues, in October 2011 the Treatment Collaborative for Traumatized Youth will be adding the treatment method of Alternative for Families – Cognitive Behavioral (AF-CBT) as part of the evidence based practice training and therapy offered at the eight Human Service Center. AF-CBT is evidence based practice, family-centered treatment designed to address family conflict, coercion and hostility, emotional abuse, and child physical abuse. AF-CBT teaches individual and family skills to strengthen family relationships and safety routines using coordinated and structured training methods. The goals of AF-CBT are to help family members improve their communication and problem-solving skills, help parents learn skills to effectively support and discipline their children, and help children manage difficult emotions and respond more positively to challenges.

This training methods seek to help family members improve their communication and problem solving skills, help parents to effectively support and discipline their children, and help children manage difficult emotions and respond more competently to interpersonal challenges.

There will be 24 AF-CBT program training slots offered to the Human Service Center Clinicians and Intensive In-Home Therapists. An application process will be used to select the 24 participants.

**Need for a quick response rate on the data that is collected by the clinicians implementing SPARCS, TF-CBT & AF-CBT that provides a clinical impression on the assessments completed pre and post treatment. The Department of Mental Health & Substance Abuse & Neuropsychiatric Research Institute is working closely with Dr. Jason Lang to establish the use of Google Doc to provide the clinicians a rapid scoring on the instruments utilized in treatment.

The TCTY initiative is in collaboration with Dr. Steve Wonderlich, from the UND Medical School Neuroscience Department. The Division of Mental Health and Substance Abuse Services along with the Children and Family Services Division have made a commitment to support the continued implementation of evidence-based practices in both Children's Mental Health and Child Welfare System for the next two years (2011-2013).

Transition to Independence Program Unmet Need: In an effort to determine the unmet needs of the transition aged population in North Dakota, a survey was completed in January 2011 of stakeholders across North Dakota. Invitations to participate in the survey were sent to 387 individuals and 253 (65%) responded. Stakeholders included, parents, youth, private and public agencies who are directly involved in working with this population. The survey responses

were categorized into five major problem areas the Transition to Independence Program needs to pay attention to and plan for during the next five years. The problem areas identified include:

1. Housing and Transportation: Lack of availability & affordability.
2. Jobs & employability: Lack of job sills & soft skills, lack of available jobs.
3. Support systems: The need for and/or lack of a wide range of supports identified as critical for transition.
4. Health: Mental & physical health issues along with disabilities that impede successful transition.
5. Management systems: The need for and/or lack of coordinated systems that foster successful transition.

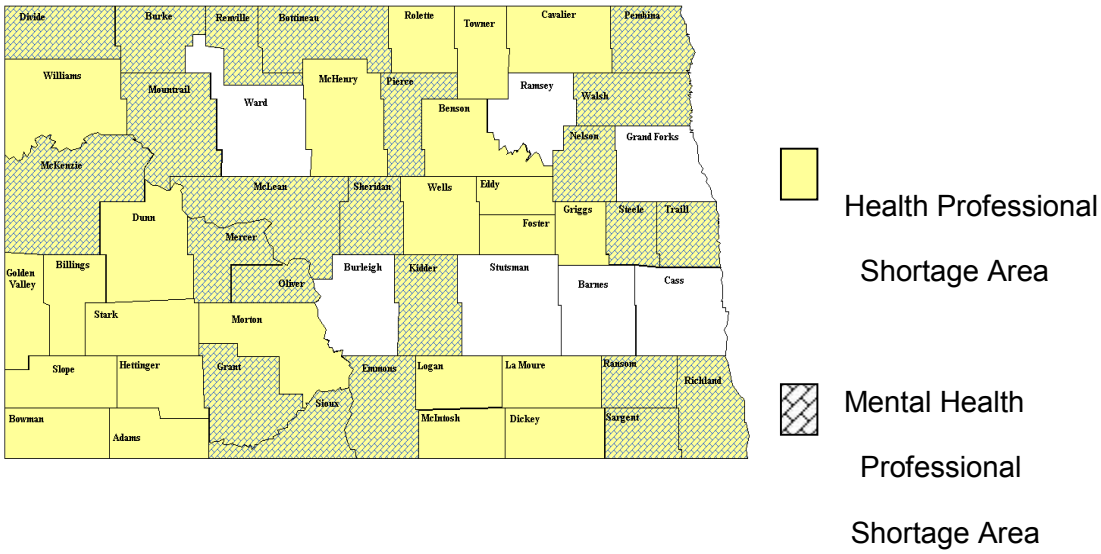
DUAL DIAGNOSIS (SED/SA) SERVICES: The North Dakota Department of Human Services provides service to individuals who are dually diagnosed with a serious emotional disorder and a substance abuse disorder. The regional human service centers offer dual diagnosis programs ranging from group therapy to intensive case management.

To help coordinate dual disorder programs across the state, the Division of Mental Health and Substance Abuse Services hired an Administrator of Mental Health/Substance Abuse Programs. This position is responsible for planning, policy development and implementation, and program oversight of the MI/SA system of care across North Dakota.

MENTAL HEALTH PROFESSIONAL SHORTAGE AREA

As you can see in the figure below, much of North Dakota is considered a health and mental health professional shortage area. Eighty-one percent of the state (43/53 counties) is designated as partial or full county HPSAs. Many federal programs use HPSA designations as a means to target federal resources.

Figure 2. North Dakota Health and Mental Health Professional Shortage Areas



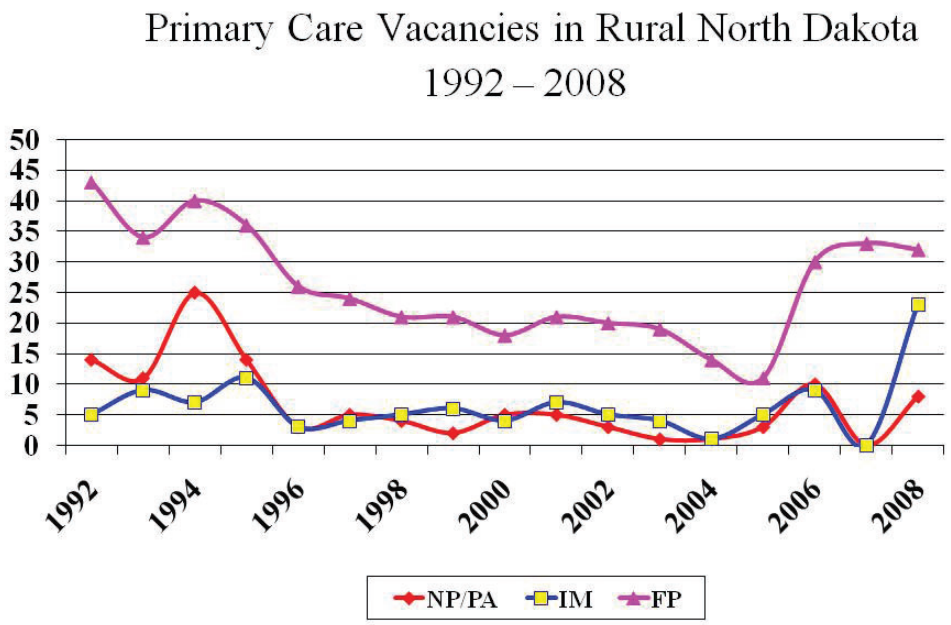
According to the most recent data available from the North Dakota Center for Rural Health, North Dakota had 1,461 licensed physicians in 2004. Of the state's 328 practicing family medicine physicians, 68 percent (222/328) graduated from the University of North Dakota, with a medical degree, or residency training, or both. Nationally, 11 percent of U.S. physicians practice in rural areas as compared to 32 percent in North Dakota (Rural Health Facts: Primary Care Providers, Center for Rural Health, UNDSMHS, Summer, 2005). Family medicine physicians provide the majority of patient care in rural areas.

One measure related to the demand for health care professionals is the number of unfilled positions or vacancies. In 2004, 92 physician vacancies were reported. Of those, 34 were reported in rural communities and 58 reported in three of the four state's urban cities. Vacancies in rural areas remain fairly stable with an average of 18 openings reported for Family Medicine each quarter from 1992-2005. Family Medicine constitutes the highest number of rural vacancies while subspecialty vacancies dominate in urban areas (North Dakota Physician Survey, Center for Rural Health, UNDSMHS, 2004). Vacancies across rural areas of North Dakota increased slightly between 2004 and 2005 (rural defined as communities other than Minot, Bismarck, Grand Forks, Bismarck/Mandan, Fargo, and Jamestown).

According to the March 2009 Center for Rural Health report – "An Environmental Scan of Health and Healthcare in North Dakota: Establishing the Baselines for Positive Health Transformation" – primary care physicians, especially family medicine physicians, are the most sought after specialty in rural areas. After a decade of declining numbers in students choosing family medicine as a specialty, the 2008 National Residency Program Match showed a slight increase in the number of U.S. medical school seniors choosing family medicine. However, students continue to express a preference for non-primary care specialties as evident in the decrease of seniors choosing internal medicine or pediatrics (Pugno, McGaha, Schmittling, DeVilbiss, & Ostergaard, 2008). In North Dakota, 44 family medicine physicians are needed to meet demand in the state. Total reported health care provider vacancies indicate a need for 271 physicians, nurses, clinical laboratory science, mental health, and X-ray technicians (Amundson, 2008).

Psychologists and Licensed Addiction Counselors are two additional professions that are difficult to fill in North Dakota.

Another important dimension of workforce has to do with urban versus rural preference of providers. Nationally, in 2005, only 11% of recent medical school graduates chose rural practice. With about 125 public medical schools in the nation, the University of North Dakota ranked 6th in terms of *graduates selecting rural practice.* Tracking graduates from 1988 to 1997 and then analyzing where they were practicing in 2005, 28% of ND graduates are in rural settings. West Virginia is 1st with 41% selecting rural practice sites.



NP: Nurse Practitioner PA: Physician Assistant IM: Internal Medicine FP: Family Practice

Regarding other health care disciplines, Job Service of North Dakota expects significant growth (over 10%) in demand for pharmacists, occupational therapists, physical therapists, medical and clinical laboratory technologists and technicians, physician assistants, and registered nurses. In response to workforce needs, federal and state policymakers have developed programs to increase the supply of some categories of health professionals and to provide technical assistance to health facilities and placement sites. For example, the National Health Service Corps uses federal scholarships and loan repayment options as incentives to recruit new providers into health professional shortage areas. North Dakota, like many states, has its own loan repayment programs for primary care physicians, dentists, nurse practitioners, nurse midwives, and physician assistants.2 federally funded Primary Care Offices and designated health care delivery sites (e.g., federally qualified health centers and federally certified rural health clinics) are also examples of programs designed to address access-to-care challenges. In North Dakota, there is very little information available about the supply and demand of a number of important disciplines, including occupational therapists, physical therapists, mental health care providers, and other allied health professionals. As a result, it is difficult to calibrate supply to meet anticipated demand through educational or policy options or both.

Category	Total Numbers	Male	Female	Average Age State vs. National	Retirement	Race	National Ranking
Physicians	1461(2004)3	79% vs. 74% nationally	21%	49/51	26% by 2015	80% non-Hispanic white	31 for # of active physicians/100,000
Nursing	12,2891	5%	95%	RNs 44/472LPN 42/44	25% by 20162	96% non-Hispanic white1	N/A
Dentists	327	86% vs. 71% nationally	14%	52/49	51% by 2023	97% non-Hispanic vs. 87% nationally	N/A
Source: 1North Dakota Board of Nursing Annual Report (2007–2008)|2Nursing Needs Testimony (Moulton, 2008)3A Survey of North Dakota Physicians Health Profession Tracking Program (Amundson et al., 2005)							

The high incidence of suicide in North Dakota may be due, in part, to the lack of access to behavioral health services. The 2010 data ranks North Dakota 9th in the nation for suicides for all ages, with 103 individuals taking their own lives. An increase in the number of suicides occurred in the 10-24 and 65 years plus age categories. Between 2000 and 2010, there were 938 reported suicides in North Dakota, 803 whites, 119 Native Americans, and 16 other racial minorities. Although the white population had seven times more deaths by suicide than the Native American population in the last 10 years, because of the population base, the suicide rate for Native Americans were almost three times that of the white population. The current highest suicide rate for North Dakota is 22.2 per 100,000 population in the 35 to 44 age group. For the 65 and older age group, suicide rates were 17.4 per 100,000 population.

Multiple Admissions to State Hospital: Nearly one-quarter of the individuals admitted to the State Hospital in recent years had been admitted multiple times during the year.

Corrections: An estimated one in ten inmates in North Dakota's prison system has a serious mental illness diagnosis.

PRIORITY STATUS
Services for persons with or at risk of having substance use and/or mental health disorders:

Persons who are Intravenous drug users

North Dakota defines intravenous Drug Users (IDUs) as an individual who requests and is in need of substance abuse treatment, who reports any intravenous or intramuscular substance use (other than as directed by a physician for medical purposes) within the past year.

The regional human service centers provide service on request to priority populations seeking substance abuse treatment in compliance with 45 C.F.R. 96.126. At the initial phone contact, all clients seeking alcohol and drug services are screened to determine if they are intravenous drug users. If they report IV drug use in the past year, they are given preference for admission and scheduled or offered an appointment within 48 hours to be evaluated and referred to the appropriate level of care. All programs reported that they were able to provide admission and treatment upon demand to this population.

To ensure compliance with block grant requirements, the regional human service centers entered into an Assurance of Compliance with Rules and Regulations with the Division of Mental Health and Substance Abuse Services (DMHSAS). In this agreement, it is stated in order to remain eligible for SAPT Block Grant funding, the center must agree to and comply with the specific SAPT Block Grant requirements, including capacity management and interim services for IDUs. It is clearly identified that each program shall provide IDUs with preference for admission to treatment. All clients requesting substance abuse services are screened for IV drug use and if they report use are scheduled or offered an appointment for admission within 48 hours. If the center does not have the capacity to admit the client to the appropriate level of treatment within 14 days, they are to provide written notification to DMHSAS, place the client's name and case number on a waiting list, and within 48 hours provide interim services for the client. Interim services are defined as case management, education, referrals to public health for testing, and alcohol/drug screening. The Assurance of Compliance with Rules and Regulations is reviewed and discussed quarterly with all alcohol and drug unit supervisors. In the event interim services cannot be provided, DMHSAS will be notified of the client's name and case number and arrangements will be made for provision of services by another agency.

Compliance with this requirement is monitored biennially during onsite visits to each regional human service center, including a file audit. Case files of those clients who are identified in our management information system can be pulled and reviewed electronically as to whether the appropriate services were provided in the time frames specified within the block grant. Through our management information system, a monthly report of client list of initial contacts reviewed by priority are printed to review and scrutinized by a division staff to determine compliance.

Women who are pregnant and have a substance use disorder
The regional human service centers screen all admissions for preference as required in 45 C.F.R. 96.131 at initial contact. All regional human service centers and the Division have toll-free phone numbers. If the client identified as being a pregnant woman they were scheduled or offered appointments within 48 hours. All programs reported that they were able to provide admission and treatment to this population upon demand and therefore did not have a need to provide interim services.

Women with substance use disorder who have dependent children

Two women specific residential substance abuse programs (program associated with North Central Human Service Center and a program as part of North East Human Service Center) continues to be funded for providing women's specific services, targeting pregnant women and women with dependent children. These residential treatment programs, as part of North Central Human Service Center (NCHSC) in Minot, ND (ND 900072), which covers a seven-county area in the North Central Region of the state and Northeast Human Service Center (NEHSC) in Grand Forks, ND (ND 100145), which covers a four-county area in the Northeast Region of the state.

NCHSC and NEHSC will continue to provide services to pregnant women and women with dependent children from all regions of the state. Services include substance abuse treatment, family therapy, family/child assessments, residential services, day care, job search assistance, classes on parenting including support and education, budgeting, nutrition, social skills and healthy relationships, transportation to and from treatment, coordination of health services including medical appointments, services and meetings with county social services and WIC (Women, Infants and Children). Regional human service centers will continue to provide services for women and women with dependent children and expand activities as need arises.

Referrals to these programs are enhanced through the use of the electronic record as all human service center programs can access client history (including treatment history), and improve the continuity of care (transitioning from admission, through continued care and discharge from a residential facility).

The State ensured compliance with the women's set-aside requirement program administration and fiscal administration reviews. Fiscally, both NCHSC and NEHSC coded each of the women served in their program differently than other clients so their services could be drawn down from the set-aside amount. NCHSC and NEHSC were responsible for submitting annual reports and upon additional requests, regarding the services provided. These programs are also reviewed during biennial licensure visits.

Capacity Management:

The eight regional human service centers are required and responsible to comply with all requirements of the SAPT Block Grant including capacity management and waiting list systems. The Division of Mental Health and Substance Abuse Services (DMHSAS) has worked with the regional human service centers to create a signed Assurance of Compliance with Rules and Regulations outlining all activities required for receipt of SAPT Block Grant funds. Items included in this assurance include:

- Capacity management–Intravenous Drug Users (IVDU's);
- Capacity management–Pregnant women; and
- Interim services requirements for pregnant women and IVDU's

The Division maintains a toll-free number. Providers are also instructed to call 1-800-755-2719 or e-mail immediately if they are unable to admit and/or provide interim services for intravenous drug users and pregnant women. These issues are also discussed at the Alcohol and Drug Supervisors quarterly meetings.

Interim services are intended to reduce the adverse health effects of alcohol and other drug abuse, promote the health of the individual, and reduce the risk of transmission of disease. For pregnant women, interim services shall include counseling on the effects of alcohol and drug use on the fetus, as well as referral for prenatal care. At a minimum, interim services for other

populations shall include education on HIV and TB and risks of transmission, case management, referrals for testing to public health or primary physician, and alcohol/drug screening.

When interim services are provided, the client will be seen at least weekly by a case management staff member who will provide education on a 1:1 basis. During this time, referrals to public health for testing and/or prenatal care and alcohol/drug screening can be managed. In the event interim services cannot be provided, DMHSAS will be notified of the client's name and case number and arrangements will be made for provision of services by another agency but to date, this has not been used.

North Dakota does not track expenditure data for capacity management and wait list system for intravenous drug users and pregnant women as toll-free phone numbers and e-mail capability are part of the daily operation within the Department of Human Services (DMHSAS and the regional human service centers).

During biennial licensure review and the Independent Peer Review, all centers are monitored for their compliance with 45 C.F.R. 96.131 (f). Files are audited to review documentation showing that any client requesting alcohol or drug treatment services has been screened for admission preference. All centers have a policy in place and forms for the file verifying that all clients have been told that the preference for admission to treatment is as follows:

- Pregnant injecting drug users;
- Pregnant substance abusers;
- Injecting drug users; and
- All others.

Clients who identify being a pregnant injecting drug user, pregnant substance abuser, or an injecting drug user are given priority and scheduled (or offered an appointment) for admission within 48 hours. Monthly reports are compiled and reviewed by DMHSAS staff and if questions or problems are noted, the human service center is contacted to resolve the issue. These reports by region are available to AOD Supervisors. Additionally, all centers have signed an Assurance of Compliance with Rules and Regulations verifying that they acknowledge this requirement and will comply.

Services for persons with or at risk of contracting communicable diseases:

Individuals with tuberculosis

Based on chapter 75-09.1-01-11 of the North Dakota Substance Abuse Treatment Program Administrative Rule, licensed substance abuse treatment programs are required to have a written infection control policy that complies with all applicable state and federal laws and regulations. Programs must review the written policy at least annually and at other times as necessary. The program must provide screening or referral procedures and must include a documented verbal assessment of high-risk behaviors for tuberculosis (TB), hepatitis, HIV and other blood-borne and sexually transmitted diseases. The program must implement a practical system developed for reporting, evaluating and maintaining records of infections among clients. The treatment program must implement written policies for the handling of all bodily fluids and must take universal precautions in the handling of all bodily fluids. The licensed treatment program must have a written plan for the instruction of new employees in the importance of infection control and personal hygiene and their responsibility in the infection control program.

As identified in the Assurance of Compliance with Rules and Regulations, regional human service centers are required to, either directly or through arrangements with their local/county health departments, routinely make available the following tuberculosis services:

- provide counseling on tuberculosis
- testing to determine if the individual has been infected with mycobacterium tuberculosis to determine appropriate treatment
- Provide for or refer an individual infected by mycobacterium tuberculosis for appropriate medical evaluation and treatment.

If an individual is denied tuberculosis services due to lack of capacity of the program to admit, refer the individual to another provider of tuberculosis services.

The Regional Directors of the human service centers have reported that they have implemented infection control procedures as required and they have been working with the local health departments to ensure the provision of required TB and HIV services in their regions. Substance abuse clients are screened at the time of intake and assessed of high-risk behaviors to determine if they are at risk for infection of TB, hepatitis, HIV and other blood-borne and sexually transmitted diseases. High-risk clients are then referred for testing and additional services. The North Dakota Department of Health is mandated by State law (NDAC Chapter 33-12) and thus coordinates TB service needs of the citizens of the State. State general fund dollars, budgeted through the North Dakota Department of Health, are used for these services though some federal dollars have been allocated to TB laboratory services. To date, the agency has had the funding necessary to meet the state's TB services needs.

All eight of the regional human service centers have policy and procedures in place regarding tuberculosis services including testing and referral for tuberculosis in accordance with the requirements in 45 C.F.R. 96.127 and a policy to provide screening or referral procedures in North Dakota Department of Human Services Administrative Code, Chapter 75-09.1-01-11. All clients requesting alcohol and drug services are screened for high-risk behaviors associated with tuberculosis during the initial assessment. All clients are given the opportunity to be tested for tuberculosis either through on-site testing or a referral to the local public health unit. All positive tests are to be reported, as required by law (North Dakota Century Code, Chapter 23-07) to the North Dakota Department of Health, Division of Disease Control.

Independent peer review teams review each human service center biennially and compliance with the requirement of tuberculosis services is assessed. The Division conducts licensure reviews biennially with each of the human service centers and the requirement of tuberculosis services is monitored.

Each of the regional human service centers continue to follow policy and procedures to provide in-service training on tuberculosis to staff and to screen and make tuberculosis services available to individuals receiving substance abuse treatment. The human service centers agree to:

1. Directly or through collaboration with other health care providers, tuberculosis services are available. These services include counseling on mycobacteria tuberculosis, testing to determine if infected with mycobacteria tuberculosis to determine appropriate treatment, and to provide for or refer an individual infected with mycobacteria tuberculosis;
2. Refer individuals to another provider of tuberculosis services if the program does not have the capacity to admit;

3. Implement infection control procedures in compliance with North Dakota Department of Human Services Administrative Code, Chapter 75-09.1-01-11 and as required in 45 C.F.R. section 96.127;
4. Provide case management activities to ensure that individuals receive these services; and
5. All individuals identified with active tuberculosis shall be reported to the appropriate State official as required by law.

As part of the Assurance of Compliance with Rules and Regulations, all regional human service centers have agreed to provide or make available tuberculosis (TB) services and meet all state reporting requirements while adhering to Federal and State confidentiality requirements. During biennial licensure reviews, all centers are monitored for compliance with this issue. All substance abuse treatment programs must have a policy that includes screening or referral procedures and must include a documented verbal assessment of high-risk behaviors for TB as required per the substance abuse treatment program administrative code NDAC 75-09.1. As a result, failure to comply with this requirement could result in conditions being imposed. If conditions were cited, the center would have thirty days to submit a plan of corrective action and sixty days after the plan is submitted to implement the plan and satisfy the condition. If continued noncompliance occurred, the DMHSAS shall revoke the provider's license immediately.

All of the regional human service centers have policies in place for the screening and referral of clients for TB services, including testing, medical evaluation and treatment, and counseling. Testing is provided either onsite at the human service center or through coordination with local public health units, which are funded by the ND Department of Health, Division of Disease Control. All positive tests are to be reported to the ND Department of Health in accordance with North Dakota Century Code, Chapter 23-07 and North Dakota Administrative Code Chapter 33-06-02.

Persons with or at risk for HIV/AIDS and who are in treatment for substance abuse
North Dakota's rate for cases of acquired immune deficiency syndrome falls below the threshold of 10 per 100,000 individuals and as a result, North Dakota as a non-designated state and the requirements regarding human immunodeficiency virus are non-applicable.

TARGET POPULATION: The Federal Register, Volume 62, No. 60 dated Friday, March 28, 1997, defines serious mental illness and the Federal Register, Volume 64, No. 121 dated Thursday, June 24, 1999 estimates that North Dakota has 25,024 individuals with serious mental illnesses. In SFY 2008, the estimate for adults with serious mental illness (26,833) and children and adolescents (5,855) is 32,688.

Definition of Adults with Serious Mental Illnesses

Pursuant to Section 1912 (c) of the Public Health Service Act, as amended by Public

Law 102-321 "adults with a serious mental illness" are persons:

- age 18 and over
- who currently, or at any time during the past year
  - have had a diagnosable mental, behavioral, or emotional disorder of sufficient duration to meet diagnostic criteria specific within DSM-IV

- that has resulted in functional impairment which substantially interferes with or limits one or more major life activities

These disorders include any mental disorders (including those of biological etiology) listed in DSM-IV-TR or their ICD-10 equivalent, with the exception of DSM-IV "V" codes, substance use disorders and developmental disorders which are excluded unless they co-occur with another diagnosable serious mental illness. All of these disorders have episodic, recurrent or persistent features; however, they vary in terms of severity and disabling effects.

Functional impairment is defined as difficulties that substantially interfere with or limit role functioning in one or more major life activities including basic daily living skills (e.g., eating, bathing, dressing); instrumental living skills (e.g., maintaining a household, managing money, getting around the community, taking prescribed medication); and functioning in social, family, and vocational/educational contexts.

Definition of Children with Severe Emotional Disturbance (SED)

Children with Severe Emotional Disturbances (SED) meet the following eligibility criteria:

- Age 18 or less
- Diagnosed with an emotional, behavioral, or mental disorder
- Placed out-of-home, are at imminent risk of out-of-home placement, or have a Global Assessment of Functioning score (GAF) of 50 or below
- Have service needs involving two or more community agencies such as mental health, substance abuse, education, juvenile justice, health, or child welfare
- Must have or be expected to have the disorder for one year or more

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II: Planning Steps

Table 2 Step 3: Prioritize State Planning Activities

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Start Year:

End Year:

Number	State Priority Title	State Priority Detailed Description
1	Military Families	Mental Health and Substance Abuse Prevention and Treatment services targeted to men/women in the military, veterans, and their families.
2	Trauma and Justice	Reducing the pervasive, harmful, and costly health impact of violence and traina by integrating trauma-informed approaches throughout health, hebavioral health, and related systems and addressing the behavioral health needs of people involved or at risk of involvement in the criminal and juvenile justice systems.
3	Prevention	Creating communities where individuals, families, schools, faith-based organizations, and workplaces take action to promote emotional health and reduce the likelihood of mental illness, substance abuse including tobacco, and suicide.
4	Recovery Support	Partnering with people in recovery from mental and substance use disorders to guide the hevioral health system and promote individual, program, and system-level approaches that foster heath and resilience; increase permanent housing, employment, education, and other necessary supports; and reduce barriers to social inclusion.
5	Public Awareness and Support	Increasing understanding of mental and substance use disorders to achieve the full potential of prevention, help people recognize mental and substance use disorders and seek assistance with the same urgency as any other health condition, and make recovery the expectation.
6	Data, Outcomes, and Quality	Realizing an integrated data strategy that informs policy and measures program impact leading to improved quality of services and outcomes for individuals, families, and communities.

Footnotes:

II: Planning Steps

Table 3 Step 4: Develop Objectives, Strategies and Performance Indicators

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Start Year:

End Year:

Priority	Goal	Strategy	Performance Indicator	Description of Collecting and Measuring Changes in Performance Indicator
Military Families	Assure adequate and consistant services delivery to miliary representatives, veterans, and families.	Determine what services are provided and by whom. Increase communication, collaboration, and training at the state and local level.	Increase number of trainings and inclusion of military representatives, veterans, and families.	Increase number of trainings and involvement with/from military representatives, veterans, and families. Identify Baseline Data. Increase/build systems capacity to serve military representatives, veterans, and families. Identify Baseline Data.
Trauma and Justice	Increase awareness of the impacts of trauma	Define trauma. Develop a plan to assess the current system.	Develop a plan for the assessment of current systems.	A plan for the assessment of current systems will be developed prior to April of 2014.
Prevention	Assess and develop a plan for networked systems to apply resources to the promotion of mental health and prevention of mental, emotional, and behavioral health disorders.	Assess the current systems Develop a plan	Develop a plan for the assessment of the behavioral health promotion and prevention systems.	A plan for the assessment of current systems will be developed prior to April of 2014.
	A recovery model that encompasses a			

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Recovery Support	continuum of care that recognizes the interconnections of behavioral health (promotion, prevention, treatment, and recovery).	Assess current recovery supports. Create a plan to develop/enhance recovery options.	Develop a plan based on the assessment of recovery supports.	A plan based on the assessment of recovery supports will be developed prior to April of 2014.
Public Awareness and Support	Assess and develop a plan for the increased understanding of mental, emotional, and behavioral health disorders by the general public.	Assess current level of understanding of mental, emotional, and behavioral health disorders by the general public. Create a plan to develop/enhance the understanding of mental, emotional, and behavioral health disorders by the general public.	Develop a plan based on the assessment of the understanding of mental, emotional, and behavioral health disorders by the general public.	A plan based on the assessment of the understanding of mental, emotional, and behavioral health disorders by the general public will be developed prior to April of 2014.
Data, Outcomes, and Quality	Develop a continuous quality improvement plan.	Assess existing data sources Complete a data gap analysis Implement an comprehensive, integrated reporting mechanism Develop a performance outcome plan	Develop a performance outcome plan	A performance outcome plan will be developed prior to April of 2014.

Footnotes:

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III: Use of Block Grant Dollars for Block Grant Activities

Table 4 CMHS - Services Purchased Using Reimbursement Strategy

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Start Year:

End Year:

Reimbursement Strategy	Services Purchased Using the Strategy
No Data Available	

Footnotes:

III: Use of Block Grant Dollars for Block Grant Activities

Table 4 SAPT - Services Purchased Using Reimbursement Strategy

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Start Year:

End Year:

Reimbursement Strategy	Services Purchased Using the Strategy
No Data Available	

Footnotes:

III: Use of Block Grant Dollars for Block Grant Activities

Table 5 CMHS - Projected Expenditures for Treatment and Recovery Supports

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Start Year:

End Year:

Category	Service/Activity Example	Estimated Percent of Funds Distributed
Healthcare Home/Physical Health	• General and specialized outpatient medical services • Acute Primary Care • General Health Screens, Tests and Immunization • Comprehensive Care Management • Care coordination and health promotion • Comprehensive transitional care • Individual and Family Support • Referral to Community Services	N/A 6
Engagement Services	• Assessment • Specialized Evaluation (Psychological and neurological) • Services planning (includes crisis planning) • Consumer/Family Education • Outreach	N/A 6
Outpatient Services	• Individual evidence-based therapies • Group therapy • Family therapy • Multi-family therapy • Consultation to Caregivers	N/A 6
Medication Services	• Medication management • Pharmacotherapy (including MAT) • Laboratory services	N/A 6
Community Support (Rehabilitative)	• Parent/Caregiver Support • Skill building (social, daily living, cognitive) • Case management • Behavior management • Supported employment • Permanent supported housing • Recovery housing • Therapeutic mentoring • Traditional healing services	N/A 6
Recovery Supports	• Peer Support • Recovery Support Coaching • Recovery Support Center Services • Supports for Self Directed Care	N/A 6
Other Supports (Habilitative)	• Personal care • Homemaker • Respite • Supported Education • Transportation • Assisted living services	N/A 6

	• Recreational services • Interactive Communication Technology Devices • Trained behavioral health interpreters	
Intensive Support Services	• Substance abuse intensive outpatient services • Partial hospitalization • Assertive community treatment • Intensive home based treatment • Multi-systemic therapy • Intensive case management	N/A 6
Out-of-Home Residential Services	• Crisis residential/stabilization • Clinically Managed 24-Hour Care • Clinically Managed Medium Intensity Care • Adult Mental Health Residential • Adult Substance Abuse Residential • Children's Mental Health Residential Services • Youth Substance Abuse Residential Services • Therapeutic Foster Care	N/A 6
Acute Intensive Services	• Mobile crisis services • Medically Monitored Intensive Inpatient • Peer based crisis services • Urgent care services • 23 hour crisis stabilization services • 24/7 crisis hotline services	N/A 6
Prevention (Including Promotion)	• Screening, Brief Intervention and Referral to Treatment • Brief Motivational Interviews • Screening and Brief Intervention for Tobacco Cessation • Parent Training • Facilitated Referrals • Relapse Prevention /Wellness Recovery Support • Warm line	N/A 6
System improvement activities		N/A 6
Other		N/A 6

Footnotes:

III: Use of Block Grant Dollars for Block Grant Activities

Table 5 SAPT - Projected Expenditures for Treatment and Recovery Supports

Page 30 of the Application Guidance

Start Year:

End Year:

Category	Service/Activity Example	Estimated Percent of Funds Distributed
Healthcare Home/Physical Health	• General and specialized outpatient medical services • Acute Primary Care • General Health Screens, Tests and Immunization • Comprehensive Care Management • Care coordination and health promotion • Comprehensive transitional care • Individual and Family Support • Referral to Community Services	N/A
Engagement Services	• Assessment • Specialized Evaluation (Psychological and neurological) • Services planning (includes crisis planning) • Consumer/Family Education • Outreach	N/A
Outpatient Services	• Individual evidence-based therapies • Group therapy • Family therapy • Multi-family therapy • Consultation to Caregivers	N/A
Medication Services	• Medication management • Pharmacotherapy (including MAT) • Laboratory services	N/A
Community Support (Rehabilitative)	• Parent/Caregiver Support • Skill building (social, daily living, cognitive) • Case management • Behavior management • Supported employment • Permanent supported housing • Recovery housing • Therapeutic mentoring • Traditional healing services	N/A
Recovery Supports	• Peer Support • Recovery Support Coaching • Recovery Support Center Services • Supports for Self Directed Care	N/A
Other Supports (Habilitative)	• Personal care • Homemaker • Respite • Supported Education • Transportation • Assisted living services	N/A

	• Recreational services • Interactive Communication Technology Devices • Trained behavioral health interpreters	
Intensive Support Services	• Substance abuse intensive outpatient services • Partial hospitalization • Assertive community treatment • Intensive home based treatment • Multi-systemic therapy • Intensive case management	N/A 6
Out-of-Home Residential Services	• Crisis residential/stabilization • Clinically Managed 24-Hour Care • Clinically Managed Medium Intensity Care • Adult Mental Health Residential • Adult Substance Abuse Residential • Children's Mental Health Residential Services • Youth Substance Abuse Residential Services • Therapeutic Foster Care	N/A 6
Acute Intensive Services	• Mobile crisis services • Medically Monitored Intensive Inpatient • Peer based crisis services • Urgent care services • 23 hour crisis stabilization services • 24/7 crisis hotline services	N/A 6
Prevention (Including Promotion)	• Screening, Brief Intervention and Referral to Treatment • Brief Motivational Interviews • Screening and Brief Intervention for Tobacco Cessation • Parent Training • Facilitated Referrals • Relapse Prevention /Wellness Recovery Support • Warm line	N/A 6
System improvement activities		N/A 6
Other		N/A 6

Footnotes:

III: Use of Block Grant Dollars for Block Grant Activities

Table 6 CMHS - Primary Prevention Planned Expenditures Checklist

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Start Year:

End Year:

Strategy	IOM Target	Block Grant FY 2012	Other Federal	State	Local	Other
Information Dissemination	Universal	$	$	$	$	$
Information Dissemination	Selective	$	$	$	$	$
Information Dissemination	Indicated	$	$	$	$	$
Information Dissemination	Unspecified	$	$	$	$	$
Information Dissemination	Total	$	$	$	$	$
Education	Universal	$	$	$	$	$
Education	Selective	$	$	$	$	$
Education	Indicated	$	$	$	$	$
Education	Unspecified	$	$	$	$	$
Education	Total	$	$	$	$	$
Alternatives	Universal	$	$	$	$	$
Alternatives	Selective	$	$	$	$	$
Alternatives	Indicated	$	$	$	$	$
Alternatives	Unspecified	$	$	$	$	$
Alternatives	Total	$	$	$	$	$
Problem Identification and Referral	Universal	$	$	$	$	$
Problem Identification and Referral	Selective	$	$	$	$	$
Problem Identification and Referral	Indicated	$	$	$	$	$
Problem Identification and Referral	Unspecified	$	$	$	$	$
Problem Identification and Referral	Total	$	$	$	$	$

Community-Based Process	Universal	$	$	$	$	$
Community-Based Process	Selective	$	$	$	$	$
Community-Based Process	Indicated	$	$	$	$	$
Community-Based Process	Unspecified	$	$	$	$	$
Community-Based Process	Total	$	$	$	$	$
Environmental	Universal	$	$	$	$	$
Environmental	Selective	$	$	$	$	$
Environmental	Indicated	$	$	$	$	$
Environmental	Unspecified	$	$	$	$	$
Environmental	Total	$	$	$	$	$
Section 1926 Tobacco	Universal	$	$	$	$	$
Section 1926 Tobacco	Selective	$	$	$	$	$
Section 1926 Tobacco	Indicated	$	$	$	$	$
Section 1926 Tobacco	Unspecified	$	$	$	$	$
Section 1926 Tobacco	Total	$	$	$	$	$
Other	Universal	$	$	$	$	$
Other	Selective	$	$	$	$	$
Other	Indicated	$	$	$	$	$
Other	Unspecified	$	$	$	$	$
Other	Total	$	$	$	$	$

Footnotes:

III: Use of Block Grant Dollars for Block Grant Activities

Table 6 SAPT - Primary Prevention Planned Expenditures Checklist

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Start Year: 2012

End Year: 2014

Strategy	IOM Target	Block Grant FY 2012	Other Federal	State	Local	Other
Information Dissemination	Universal	$	$	$	$	$
Information Dissemination	Selective	$	$	$	$	$
Information Dissemination	Indicated	$	$	$	$	$
Information Dissemination	Unspecified	$350,507	$802,673	$	$	$
Information Dissemination	Total	$350,507	$802,673	$	$	$
Education	Universal	$	$	$	$	$
Education	Selective	$	$	$	$	$
Education	Indicated	$	$	$	$	$
Education	Unspecified	$116,836	$267,558	$99,186	$	$
Education	Total	$116,836	$267,558	$99,186	$	$
Alternatives	Universal	$	$	$	$	$
Alternatives	Selective	$	$	$	$	$
Alternatives	Indicated	$	$	$	$	$
Alternatives	Unspecified	$233,672	$535,116	$	$	$
Alternatives	Total	$233,672	$535,116	$	$	$
Problem Identification and Referral	Universal	$	$	$	$	$
Problem Identification and Referral	Selective	$	$	$	$	$
Problem Identification and Referral	Indicated	$	$	$	$	$
Problem Identification and Referral	Unspecified	$0	$0	$	$	$
Problem Identification and Referral	Total	$0	$0	$	$	$

Community-Based Process	Universal	$	$	$	$	$
Community-Based Process	Selective	$	$	$	$	$
Community-Based Process	Indicated	$	$	$	$	$
Community-Based Process	Unspecified	$467,343	$1,070,231	$	$	$
Community-Based Process	Total	$467,343	$1,070,231	$	$	$
Environmental	Universal	$	$	$	$	$
Environmental	Selective	$	$	$	$	$
Environmental	Indicated	$	$	$	$	$
Environmental	Unspecified	$1,168,358	$2,675,578	$	$	$
Environmental	Total	$1,168,358	$2,675,578	$	$	$
Section 1926 Tobacco	Universal	$	$	$	$	$
Section 1926 Tobacco	Selective	$	$	$	$	$
Section 1926 Tobacco	Indicated	$	$	$	$	$
Section 1926 Tobacco	Unspecified	$18,000	$	$	$	$
Section 1926 Tobacco	Total	$18,000	$	$	$	$
Other	Universal	$	$	$	$	$
Other	Selective	$	$	$	$	$
Other	Indicated	$	$	$	$	$
Other	Unspecified	$	$	$	$	$
Other	Total	$	$	$	$	$

Footnotes:

III: Use of Block Grant Dollars for Block Grant Activities

Table 7 CMHS - Projected State Agency Expenditure Report

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Start Year: 2012

End Year: 2014

Date of State Expenditure Period From: 10/01/2011 Date of State Expenditure Period To: 09/30/2013

Activity	A. Block Grant	B. Medicaid (Federal, State, and Local)	C. Other Federal Funds (e.g., ACF (TANF), CDC, CMS (Medicare) SAMHSA, etc.)	D. State Funds	E. Local Funds (excluding local Medicaid)	F. Other
1. Substance Abuse Prevention and Treatment	$	$	$	$	$	$
2. Primary Prevention	$0	$0	$0	$0	$0	$0
3. Tuberculosis Services	$	$	$	$	$	$
4. HIV Early Intervention Services	$	$	$	$	$	$
5. State Hospital		$0	$0	$10,458,625	$0	$0
6. Other 24 Hour Care	$0	$0	$0	$0	$0	$0
7. Ambulatory/Community Non-24 Hour Care	$1,348,999	$7,049,612	$8,389,861	$21,852,921	$0	$0
8. Administration (Excluding Program and Provider Level)	$174,325	$0	$12,502	$51,211	$0	$0
9. Subtotal (Rows 1, 2, 3, 4, and 8)	$174,325	$0	$12,502	$51,211	$0	$0
10. Subtotal (Rows 5, 6, 7, and 8)	$1,523,324	$7,049,612	$8,402,363	$32,362,757	$0	$0
11. Total	$1,523,324	$7,049,612	$8,402,363	$32,362,757	$0	$0

Footnotes:

III: Use of Block Grant Dollars for Block Grant Activities

Table 7 SAPT - Projected State Agency Expenditure Report

Page 38 of the Application Guidance

Start Year: 2012

End Year: 2014

Date of State Expenditure Period From: 10/01/2011 Date of State Expenditure Period To: 09/30/2013

Activity	A. Block Grant	B. Medicaid (Federal, State, and Local)	C. Other Federal Funds (e.g., ACF (TANF), CDC, CMS (Medicare) SAMHSA, etc.)	D. State Funds	E. Local Funds (excluding local Medicaid)	F. Other
1. Substance Abuse Prevention and Treatment	$7,437,050	$1,461,478	$1,639,602	$13,610,867	$0	$0
2. Primary Prevention	$2,354,715	$0	$5,351,155	$99,186	$0	$0
3. Tuberculosis Services	$0	$0	$0	$0	$0	$0
4. HIV Early Intervention Services	$0	$0	$0	$0	$0	$0
5. State Hospital		$0	$0	$0	$0	$0
6. Other 24 Hour Care	$0	$0	$0	$0	$0	$0
7. Ambulatory/Community Non-24 Hour Care	$0	$0	$0	$0	$0	$0
8. Administration (Excluding Program and Provider Level)	$364,496	$0	$83,031	$127,664	$0	$0
9. Subtotal (Rows 1, 2, 3, 4, and 8)	$10,156,261	$1,461,478	$7,073,788	$13,837,717	$0	$0
10. Subtotal (Rows 5, 6, 7, and 8)	$364,496	$0	$83,031	$127,664	$0	$0
11. Total	$10,156,261	$1,461,478	$7,073,788	$13,837,717	$0	$0

Footnotes:

III: Use of Block Grant Dollars for Block Grant Activities

Table 8 Resource Development Planned Expenditure Checklist

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Start Year:

End Year:

Activity	A. Prevention-MH	B. Prevention-SA	C. Treatment-MH	D. Treatment-SA	E. Combined	F. Total
1. Planning, Coordination and Needs Assessment	$	$	$	$	$	$
2. Quality Assurance	$	$	$	$	$	$
3. Training (Post-Employment)	$	$	$	$	$	$
4. Education (Pre-Employment)	$	$	$	$	$	$
5. Program Development	$	$	$	$	$	$
6. Research and Evaluation	$	$	$	$	$	$
7. Information Systems	$	$	$	$	$	$
8. Total	$	$	$	$	$	$

Footnotes:

IV: Narrative Plan

D. Activities that Support Individuals in Directing the Services

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Narrative Question:

SAMHSA firmly believes in the importance of individuals with mental and substance use disorders participating in choosing the services and supports they receive. To achieve this goal, individuals and their support systems must be able to access and direct their services and supports. Participant direction, often referred to as consumer direction or self direction, is a delivery mode through which a range of services and supports are planned, budgeted and directly controlled by an individual (with the help of representatives, if desired) based on the individual's needs and preferences that maximize independence and the ability to live in the setting of his/her choice. Participant-directed services should include a wide range of high-quality, culturally competent services based on acuity, disability, engagement levels and individual preferences. The range of services must be designed to incorporate the concepts of community integration and social inclusion. People with mental and substance use disorders should have ready access to information regarding available services, including the quality of the programs that offer these services. An individual and their supports must be afforded the choice to receive services and should have sufficient opportunities to select the individuals and agencies from which they receive these services. Person centered planning is the foundation of self-direction and must be made available to everyone. The principles of person centered planning are included at www.samhsa.gov/blockgrantapplication. Individuals must have opportunities for control over a flexible individual budget and authority to directly employ support workers, or to direct the worker through a shared employment model through an agency. People must have the supports necessary to be successful in self direction including financial management services and supports brokerage. In addition, individuals and families must have a primary decision-making role in planning and service delivery decisions. Caregivers can play an important role in the planning, monitoring and delivery of services and should be supported in these roles. In the section below, please address the following:

- Either summarize your State's policies on participant-directed services or attach a copy to the Block Grant application(s).
- What services for individuals and their support systems are self-directed?
- What participant-directed options do you have in your State?
- What percentage of individuals funded through the SMHA or SSA self direct their care?
- What supports does your State offer to assist individuals to self direct their care?

Footnotes:

INDIVIDUAL DIRECTED CARE

In an effort to improve documentation of medical necessity and help move the community-based public mental health system more toward person-centered care, the Department requested technical assistance from the National Technical Assistance Center. Dr. Neal Adams, Diane Grieder, and Dr. Ed Diksa were consulted concerning implementation of Treatment Planning for Person-Centered Care. This model was chosen because it not only represents a growing and increasingly respected place in the national behavioral health care arena, but it also allows for the blending of valuing consumer strengths and goals while retaining recognition of the importance of good diagnosing and planning for the measurable clinical outcomes that reduce or resolve clinical barriers to consumer recovery. Fifty-nine staff from the regional human service centers received one-and-one-half days of preliminary training in this model. Phase 2 of the project consisted of training 24 human service center staff members as trainers of the model. This training was held in mid July of 2008. The trainers then returned to their human service center and began working with consumers on their caseloads to develop person centered treatment plans, with the continued consultation and guidance from the TA consultants. They also began training staff within the center on the practice. Phase III of the project has been the continuation and broadening of the activities of Phase II. Included have been training more clinicians on the model and modifying the Department's electronic record to aide in development of person-centered treatment plans and documenting medical necessity. Planning for Phase IV, which will occur during the upcoming fiscal year, is underway and will include further clinician and supervisor training as additional enhancements to the electronic record.

State rules prescribe standards for care plans for adults with serious mental illnesses who are served by a human service center (N.D.A.C. 75-05-04-03). The rules require that each individual have a plan, the overall development and implementation of which "are the responsibility of the professional staff member assigned the client". Furthermore, "The professional staff member assigned to the consumer shall develop and review the individual plan with the consumer, shall document in the consumer's record the consumer's input in the development and review indicating the extent of the involvement in developing the individual plan, and shall have the consumer sign the treatment plan." A plan "must contain the client's name, problems, service strategies to resolve problems, goals, names of staff members responsible for service strategies, and the signature of the case manager". "The professional staff member assigned the client shall review the individual plan with the client and shall document the review in the client's record". For "clinical services, the consumer, case manager, and case manager's supervisor shall review individual plans at least every six months, except when consumer circumstances necessitate a change to the treatment plan."

WRAP

IV: Narrative Plan

E. Data and Information Technology

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Narrative Question:

Regardless of financing or reimbursement strategy used, unique client-level encounter data should be collected and reported for specific services that are purchased with Block Grant funds. Such service tracking and reporting is required by SAMHSA to be reported in the aggregate. Universal prevention and other non-service-based activities (e.g. education/training) must be able to be reported describing the numbers and types of individuals impacted by the described activities. States should to complete the service utilization Table 5 in the Reporting Section of the Application. States should provide information on the number of unduplicated individuals by each service purchased with Block Grant Funds rather than to provide information on specific individuals served with Block Grant funds. In addition, States should provide expenditures for each service identified in the matrix. If the State is currently unable to provide unique client-level data for any part of its behavioral health system, SAMHSA is requesting the State to describe in the space below its plan, process, resources needed and timeline for developing such capacity. States should respond to the following:

- List and briefly describe all unique IT systems maintained and/or utilized by the State agency that provide information on one or more of the following:
  - Provider characteristics
  - Client enrollment, demographics, and characteristics
  - Admission, assessment, and discharge
  - Services provided, including type, amount, and individual service provider
  - Prescription drug utilization
- As applicable, for each of these systems, please answer the following:
  - For provider information, are providers required to obtain national provider identifiers, and does the system collect and record these identifiers?
  - Does the system employ any other method of unique provider identification that provides the ability to aggregate service or other information by provider?
  - Does the system use a unique client identifier that allows for unduplicated counts of clients and the ability to aggregate services by client?
  - Are client-level data in the form of encounters or claims that include information on individual date of service, type of service, service quantity, and identity of individual provider?
  - Does the system comply with Federal data standards in the following areas (use of ICD-10 or CPT/HCPCS codes)?
- As applicable, please answer the following:
  - Do provider and client identifiers in the behavioral health IT system allow for linkage with Medicaid provider identifiers that provides the ability to aggregate Medicaid and non-Medicaid provider information?
  - Are Medicaid data or linked Medicaid-behavioral health data used to routinely produce reports?
  - Does your State's IT division participate in regular meetings with Medicaid and other agencies to address mutual issues concerning system interoperability, electronic health records, Federal IT requirements or similar issues?
  - Does your State have a grant to create a statewide health information exchange and does your agency participate in the development of the exchange and in issues concerning MH/SA data?
  - Is your State Medicaid agency engaging in or planning to improve its IT system? If so, is your agency included in such efforts for the purposes of addressing issues related to data interoperability, behavioral health IT system reform, and meeting Federal IT data standards?

In addition to the questions above, please provide any information regarding your State's current efforts to assist providers with developing and using Electronic Health Records.

Footnotes:

DATA AND INFORMATION TECHNOLOGY

The following unique IT systems are used in the behavioral health system in North Dakota.

ROAP- All eight regional human services centers use this electronic record. The electronic record has one unique client identifiers used across all centers so that whatever center provides services to a client will have access to their entire EHR. This system, which is a NetSmart product, captures client specific-level data for both mental health and substance use services. The type, duration, and cost of services is captured. This is both a billing and a clinical record system. Services are captured by service area and service type. There is a ROAP code manual updated as needed. Data for the SUD program are captured on an episode of care, ASAM level, and National Outcome Measures basis. Mental health services are captured on a service specific and duration basis. For all behavioral health services, the system provides both claims data and encounter data. Each center has a national provider identifier and if a specific Medicaid service requires both the provider and the professional to be enrolled, both are completed. The system allows for unduplicated counts of clients within and across services. Services can be reported by clinician as well. Supervisory and clinician reports are generated routinely to provide administrative information. This system links with the state's Medicaid Management Information System.

This system complies with Federal data standards and uses CPT/HSPCS codes. This system is used to produce the annual URS table reports for mental health services and national outcomes measures for the SAPT block grant.

ROAP has reports generated routinely and are available on an electronic computer drive in aggregate. Specific unique reports are available through the Department's Decision Support Services Unit. The research analyst's from this unit meet with division staff routinely.

ND has a grant to build a health information exchange. The Department is participating in the development of the exchange. The division is involved in discussions on interoperability and how the behavioral health public system will be involved. The Division Director is a member of the HIE Legal and Policy Domain Workgroup. This workgroup is charged with making recommendations on the legal and privacy issues within the HIE, including behavioral health issues. The work group has also participated in the Upper Midwest HIE Consortium.

Currently, the Department is researching options and is having discussions with Netsmart to potentially pursue activation of the portions of their product tied to meaningful use and becoming a certified system.

The One Center - Two Specialized Facilities, are currently using AIMS software for managing client registration, client movement, fiscal operations, as well as clinical, such as doctors orders, treatment plans, progress notes and pharmaceutical activities. AIMS was purchased in 2001 by the vendor Netsmart Technologies . In 2001, the State of North Dakota opted to purchase the source code rather than upgrade to Netsmart Technologies replacement system. Since 2001, ND Information Technology Department has been maintaining and modifying the source code.

FRAME – FRAME is a web-based electronic record system that was implemented across systems in North Dakota, November 2009. FRAME has replaced the Single Plan of Care (SPOC) application. This web-based application captures case management activities along

with data collection & outcome reporting across systems and the life of the case. Further, the information & data collected will be used for possible longitudinal studies that follow children through systems and to provide outcomes as they enter into adulthood.

Systems currently utilizing the FRAME Electronic Record system are Children & Family Services, Human Service Centers - Partnership Care Coordination & Regional Supervisors, County Social Services (Foster Care, Child Protection Services, and In-home Services), Criminal Back Ground Check Unit, Independent Living Coordinators, Decision Support Services, Child Support, and the Department of Juvenile Services. In an effort to expand cross system use of FRAME, Children & Family Services is currently piloting a project with their contracted private providers, who provide In-Homes Services to use FRAME.

FRAME electronic record system now includes Child Protection Services (CPS) statewide. The information from CPS will be utilized to better track abuse and neglect - subjects and victims. FRAME will replace the current CPS index as this too will be integrated into the application.

CCWIPS or Comprehensive Child Welfare Information Program System will remain in operation keeping the payments process, foster home licensing and adoption.

Each individual case manager who has access to the client based information in FRAME has a security profile that is based on their level of need to access information within the electronic records system. The security profile is determined by their supervisor with a request submitted to administration, and then sent to Information Technology System (ITS) for final approval.

North Dakota will utilize FRAME to capture data for the NCANDS and AFCARS report out of FRAME. The information from FRAME will be transferred to COGNOS which is the data warehouse for FRAME. From this application, ND will be able to create reports in a variety of ways using the various fields from FRAME.

NINE STATE TEDS MENTAL HEALTH CLIENT LEVEL REPORTING PILOT: North Dakota is one of nine states participating in a pilot study to assess the feasibility of collecting client-level data on persons receiving mental health treatment services. This system will mirror the TEDS system for substance abuse services, which has been in existence for a number of years. For the Mental Health/Treatment Episode Data Set (MH/TEDS) pilot study, most TEDS data elements will be collected where available, including three (3) National Outcome Measures (NOMs) for mental health clients as currently collected in TEDS, as follows:

• Employment status (MDS 13 & DIS 24)
• Living arrangements (SUDS 8 & DIS 23)
• Arrests (for States that collect arrest information – SUDS 16 & DIS 26)

The MH/TEDS pilot study is being lead by SAMHSA's Center for Behavioral Health Statistics and Quality (CBHSQ), which is the sponsor of the main TEDS data collection. TEDS is a part of the Drug and Alcohol Services Information System (DASIS).

IV: Narrative Plan

F. Quality Improvement Reporting

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Narrative Question:

SAMHSA expects States to base their administrative operations and service delivery on principles of Continuous Quality Improvement/Total Quality Management (CQI/TQM). These CQI processes should identify and track critical outcomes and performance measures that will describe the health of the mental health and addiction systems. These measures should be based on valid and reliable data. The CQI processes should continuously measure the effectiveness of services and supports and ensure that services, to the extent possible, reflect their evidence of effectiveness. The State's CQI process should also track programmatic improvements; and garner and use stakeholder input, including individuals in recovery and their families. In addition, the CQI plan should include a description of the process for responding to critical incidents, complaints and grievances. In an attachment, please submit your State's current CQI plan.

Footnotes:

QUALITY IMPROVEMENT REPORTING

The Director of the Division of Mental Health and Substance Abuse Services has established a quality improvement program for the Division of Mental Health and Substance Abuse Services. During the Fall of 2011, work will begin on creating a formal Total Quality Improvement plan. Key indicators for behavioral health services will be developed and monitored to continually measure the effectiveness of services and supports and ensure that services perform to their utmost effectiveness.

IV: Narrative Plan

G. Consultation With Tribes

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Narrative Question:

SAMHSA is required by the 2009 Memorandum on Tribal Consultation to submit plans on how it is to engage in regular and meaningful consultation and collaboration with tribal officials in the development of Federal policies that have Tribal implications.

Consultation is an enhanced form of communication, which emphasizes trust, respect and shared responsibility. It is an open and free exchange of information and opinion among parties, which leads to mutual understanding and comprehension. Consultation is integral to a deliberative process, which results in effective collaboration and informed decision making with the ultimate goal of reaching consensus on issues. For the context of the Block Grants, SAMHSA views consultation as a government to government interaction and should be distinguished from input provided by individual Tribal members or services provided for Tribal members whether on or off Tribal lands. Therefore, the interaction should include elected officials of the Tribe or their designee. SAMHSA is requesting that States provide a description of how they consulted with Tribes in their State. This description should indicate how concerns of the Tribes were addressed in the State Block Grant plan(s). States shall not require any Tribe to waive its sovereign immunity in order to receive funds or in order for services to be provided for Tribal members on Tribal lands.

Footnotes:

CONSULTATION WITH TRIBES

Efforts have taken place over the years to engage Tribal leaders in the planning process.

Currently, the Department is working with the Indian Affairs Commissioner, Scott Davis, to plan Tribal meetings to address Medicaid and block grant efforts. Meeting with each Tribe and Department senior management, including the Director of MHSA division, will take place on tribal land over the next year. In concert with the Commissioner and Tribes, the meeting details will be developed.

The Tribal and State Relations Interim Committee is an ongoing legislative committee. Current studies underway in this committee include studying government-to-government relations, human services, education, corrections, and issues. Department staff testify as appropriate at this committee.

The Division's Substance Abuse Prevention program has partnered with Tribal Councils on each of the four federally recognized Native American Reservations. This partnership has resulted in the passing of tribal resolutions, community surveys, data collection, community education and events, and development of local-level data-driven substance abuse prevention plans. This has allowed the State to fill identified data gaps and enhance their capacity for implementing substance abuse prevention strategies.

IV: Narrative Plan

H. Service Management Strategies

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Narrative Question:

SAMHSA, similar to other public and private payers of behavioral health services, seeks to ensure that services purchased under the Block Grants are provided to individuals in the right scope, amount and duration. These payers have employed a variety of methods to assure appropriate utilization of services. These strategies include using data to identify trends in over and underutilization that would benefit from service management strategies. These strategies also include using empirically based clinical criteria and staff for admission, continuing stay and discharge decisions for certain services. While some Block Grant funded services and activities are not amenable (e.g. prevention activities or crisis services), many direct services are managed by other purchasers.

In the space below, please describe:

1. The processes that your State will employ over the next planning period to identify trends in over/underutilization of SABG or MHBG funded services
2. The strategies that your State will deploy to address these utilization issues
3. The intended results of your State's utilization management strategies
4. The resources needed to implement utilization management strategies
5. The proposed timeframes for implementing these strategies

Footnotes:

SERVICE MANAGEMENT STRATEGIES

In the space below, please describe:

1) the processes that your State will employ over the next planning period to **identify trends** in over/underutilization of SABG or MHBG funded services;

- Development of a continuous quality performance process and related reporting plan
- Request for technical assistance for under/over utilization monitoring
- Utilization and analysis of Medicaid data

2) the strategies that your State will deploy to address these utilization issues;
- To be determined when issues are identified but will include the areas of education of staff, closer monitoring of services delivered, use of high end services, length of stay in service monitoring, and pre-authorization of chosen services.

3) the intended results of your State's utilization management strategies;
- Services delivered at the right time, at the right place, and in the right amount

4) the resources needed to implement utilization management strategies; and
- Technical assistance
- Staff training
- Electronic reporting

5) the proposed timeframes for implementing these strategies.
- The assessment and development of the plan will identify timeframes

IV: Narrative Plan

I. State Dashboards (Table 10)

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Narrative Question:

An important change to the administration of the MHBG and SABG is the creation of State dashboards on key performance indicators. SAMHSA is considering developing an incentive program for States/Territories based on a set of state-specific and national dashboard indicators. National dashboard indicators will be based on outcome and performance measures that will be developed by SAMHSA in FY 2011. For FY 2012, States should identify a set of state-specific performance measures for this incentive program. These state-specific performance indicators proposed by a State for their dashboard must be from the planning section on page 26. These performance indicators were developed by the State to determine if the goals for each priority area. For instance, a state may propose to increase the number of youth that receive addiction treatment in 2013 by X%. The state could use this indicator for their dashboard.

In addition, SAMHSA will identify several national indicators to supplement the state specific measures for the incentive program. The State, in consultation with SAMHSA, will establish a baseline in the first year of the planning cycle and identify the thresholds for performance in the subsequent year. The State will also propose the instrument used to measure the change in performance for the subsequent year. The State dashboards will be used to determine if States receive an incentive based on performance. SAMHSA is considering a variety of incentive options for this dashboard program.

Plan Year:

Priority	Performance Indicator	Selected
Military Families	Increase number of trainings and inclusion of military representatives, veterans, and families.	
Trauma and Justice	Develop a plan for the assessment of current systems.	
Prevention	Develop a plan for the assessment of the behavioral health promotion and prevention systems.	
Recovery Support	Develop a plan based on the assessment of recovery supports.	
Public Awareness and Support	Develop a plan based on the assessment of the understanding of mental, emotional, and behavioral health disorders by the general public.	
Data, Outcomes, and Quality	Develop a performance outcome plan	

Footnotes:

IV: Narrative Plan

J. Suicide Prevention

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Narrative Question:

In September of 2010, U.S. Health and Human Services Secretary Kathleen Sebelius and Defense Secretary Robert Gates launched the National Action Alliance for Suicide Prevention. Among the initial priority considerations for the newly formed Action Alliance is updating and advancing the National Strategy for Suicide Prevention, developing approaches to constructively engage and educate the public, and examining ways to target high-risk populations. SAMHSA is encouraged by the number of States that have developed and implemented plans and strategies that address suicide. However, many States have either not developed this plan or have not updated their plan to reflect populations that may be most at risk of suicide including America's service men and women -- Active Duty, National Guard, Reserve, Veterans -- and their families. As an attachment to the Block Grant application(s), please provide the most recent copy of your State's suicide prevention plan. If your State does not have a suicide prevention plan or if it has not been updated in the past three years please describe when your State will create or update your plan.

Footnotes:

SUICIDE PREVENTION

The DHS is an active participant on the statewide suicide prevention coalition. The coalition meets quarterly to address the needs of ND. In 2010, the coalition completed a strategic planning process to develop a plan (see attached). The goals of the plan are: 1) Establish a sustainable operating structure for the North Dakota Suicide Prevention Coalition and 2) Prevent suicide through reduction in risk factors correlated with suicide and early identification.

In August of 2011, the suicide prevention director at the ND Department of Health formed a taskforce to assist the DoH in developing a process to conduct a needs assessment in ND. DHS is an active participant in this effort. The needs assessment will be conducted with various stakeholders and possibly a statewide community assessment at some point.

The ND Chapter of the American Foundation for Suicide Prevention was formed in 2007. The Chapter supports the annual Out of the Darkness walks every fall since September of 2006, with additional communities sponsoring a walk each year. This fall, there will be 7 community walks. Proceeds from the walk continue to support national research and prevention efforts as well as local community efforts. A program administrator from the Division co-chairs one of the local community walks. In conjunction with the president of the ND Chapter, the program administrator has presented at a number of conferences.

Information from the work of the coalition and the ND Chapter of AFSP is disseminated to the DHS on a regular basis. The Division program administrator assists with identifying training needs within the department and works with conference planning committees to sponsor training sessions.

IV: Narrative Plan

K. Technical Assistance Needs

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Narrative Question:

Please describe the data and technical assistance needs identified by the State during the process of developing this plan that will be needed or helpful to implement the proposed plan. The technical assistance needs identified may include the needs of State, providers, other systems, persons receiving services, persons in recovery, or their families. The State should indicate what efforts have been or are being undertaken to address or find resources to address these needs, and what data or technical assistance needs will remain unaddressed without additional action steps or resources.

Footnotes:

TECHNICAL ASSISTANCE NEEDS

- Service Management Strategies: North Dakota is requesting technical assistance for under/over utilization monitoring.

IV: Narrative Plan

L. Involvement of Individuals and Families

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Narrative Question:

The State must support and help strengthen existing consumer and family networks, recovery organizations and community peer advocacy organizations in expanding self advocacy, self-help programs, support networks, and recovery-oriented services. There are many activities that State SMHAs and SSAs can undertake to engage these individuals and families. In the space below, States should describe their efforts to actively engage individuals and families in developing, implementing and monitoring the State mental health and substance abuse treatment system. In completing this response, State should consider the following questions:

- •How are individuals in recovery and family members utilized in the development and implementation of recovery oriented services (including therapeutic mentors, recovery coachers and or peer specialists)?
- •Does the State conduct ongoing training and technical assistance for child, adult and family mentors; ensure that curricula are culturally competent and sensitive to the needs of individuals in recovery and their families; and help develop the skills necessary to match goals with services and to advocate for individual and family needs?
- •Does the State sponsor meetings that specifically identify individual and family members? issues and needs regarding the behavioral health service system and develop a process for addressing these concerns?
- •How are individuals and family members presented with opportunities to proactively engage and participate in treatment planning, shared decision making, and the behavioral health service delivery system?
- • How does the State support and help strengthen and expand recovery organizations, family peer advocacy, self-help programs, support networks, and recovery-oriented services?

Footnotes:

INVOLVEMENT OF INDIVIDUALS AND FAMILIES

North Dakota's Recovery-Oriented Behavioral Health Service System

Recovery Vision Statement
North Dakota's Behavioral Health System is committed to delivering recovery based services that promote feelings of self worth, self respect, independence, choice and hope to people with mental health challenges enabling them to live meaningful lives in the communities of their choice while striving to achieve their full potential.

The Division of Mental Health and Substance Abuse Services has designated the concept of recovery as the guiding principle and operational framework for the system of care provided by the partnership of state and private agencies that comprise the behavioral healthcare system. Services within this system shall identify and build upon each recovering individual's strengths and areas of health in addressing his or her needs. The environment for this system shall encourage hope and emphasize individual dignity and respect. As one of its foremost priorities, the Department shall promote recovery for persons at risk of, or who have psychiatric or substance use disorders by creating a recovery-oriented service system.

Recovery is a process rather than an event. Thus, the service system shall address the needs of people over time and across different levels of disability. Recovery principles shall be applied to the full range of engagement, intervention, treatment, rehabilitative and supportive services that a person may need. Recovery principles shall also be applied to health promotion and prevention services for those at risk of mental illness or of substance use disorders, especially those for whom selected or indicated prevention strategies are appropriate.

In keeping with this vision, and in partnership with the recovery communities, the Department shall create new and make necessary revisions to existing policies, procedures, programs, and services, and shall ensure that all new initiatives are consistent with a recovery-oriented service system. Finally, the Department shall ensure that future strategic planning and resource development efforts build upon existing strengths and continue to move the Department in the direction of promoting recovery as a core concept. In so doing, we shall firmly embed the language, spirit, and culture of recovery throughout the system of services, in our interactions with one another and with those persons and families who trust us with their care.

The recovery-oriented service system shall be notable for its quality. It thus will be marked by a high degree of accessibility, effectiveness in engaging and retaining persons in care such that they can achieve the highest degree of stability and recovery, and its effects shall be sustained rather than solely crisis-oriented or short-lived. To attain this level of quality, the recovery-oriented service system shall be age and gender appropriate, culturally competent, and attend to trauma and other factors known to impact on one's recovery. Whenever possible, services shall be provided within the person's own community setting, using the person's natural supports. The service system shall help the person to achieve an improved sense of mastery over his or her condition and assist the person to regain a meaningful, constructive sense of membership in the community.

Recovery is a person-centered approach and it thus may vary from person to person and within the mental health and addiction communities.

The following Recovery Oriented services, supports, and tools are among those available within North Dakota's Behavioral Health Care System:

Recovery Month Events

The Division of Mental Health and Substance Abuse developed a Recovery Month Event Toolkit in 2010. The purpose of the Toolkit is to assist communities with planning and funding Recovery Events held throughout the state. The Division of Mental Health and Substance Abuse Services offers stipends to eligible applicants to assist with funding these events. To date we have provided 4 stipends for events held in Bismarck, New Salem, Hebron, and Jamestown.

Recovery Month events provide a platform to celebrate people in recovery and those who serve them and serves to educate the public on substance abuse as a national health crisis, that addiction is a treatable disease, and that recovery is possible. Educating the public reduces the stigma associated with addiction and treatment. Involving community in advocacy and recovery celebrations helps change public perceptions of recovery, promote effective public policy and demonstrate that recovery is a reality for millions of Americans.

Events like rallies, runs, walks, sober social events or other activities educate people in our state about long-term recovery, engage kids and families in community-wide events, and demonstrate the joy and new life that goes along with recovery.

Recovery Centers

There is a Mental Health Recovery Center located in each of the 8 regions of North Dakota. Each Regional Human Service Center contracts with a private entity to administer the centers. The purpose of the Recovery Centers is to offer an environment of learning that promotes wellness and personal growth designed to empower individuals in recovery to live more meaningful lives in the community. Recovery Centers are member-operated and promote recovery through peer support, socialization, education, and training. By working together, members pursue life goals, build better lives for themselves, gain employment, maintain independence and become a part of their communities. The Recovery Centers offer groups, activities and resources that will empower the members to work, volunteer, attend school or further enrich their lives as they work towards recovery.

Peer Support

Peer Support Programs are located at each of the 8 Regional Recovery Centers, as well as the North Dakota State Hospital. Peer Support Services are consumer centered with rehabilitation and recovery focus designed to promote skills for coping with and managing symptoms while facilitating the utilization of natural resources and the enhancement of community living skills. Peer Support Services are provided by a person who has progressed in their own mental health recovery and is working to assist other people with mental health issues. Because of their life experience, peers have expertise that professional training cannot replicate. Peer Specialists foster their peer's ability to make informed, independent choices; help their peers recognize, and build on their strengths; and help their peers get the information and support they need from the community to make their goals a reality. Peer Specialists perform a wide range of tasks to assist peers in attaining their recovery goals. Peer Specialists undergo certification training and complete the certification process developed and recognized by the ND DHS.

The DMHSA hired a Peer Support Coordinator who oversees the Peer Support Programs across the state. This person is scheduled to attend Wellness Recovery Action Plan (WRAP) Training and will provide the information obtained to the 8 Regional Programs to enhance the utilization of WRAP across the state.

Recovery Readiness Survey:

The Division of Mental Health and Substance Abuse Services partnered with the ND Center for Persons with Disabilities to conduct the ND Organizational Self-Assessment for Recovery-Oriented Person-Centered Practices for Adults with Mental Illness a.k.a. ***The Recovery Readiness Survey.***

This project consisted of a set of surveys to gather information from adults receiving mental health services in ND as well as the professionals who administer behavioral health services in ND. The resulting survey data is used to guide efforts to provide and promote recovery-oriented person-centered services throughout the state. The information is also used to provide ongoing improvements in the way behavioral health services are provided in ND. The survey data identified what is working well in the current system and also identified challenges of the current system. The data helped determine the level of recovery readiness of mental health service providers and guide future implementation of best practices. This information will assist state agencies, policymakers, and advocates in building on the current system of behavioral health services in North Dakota.

Mental Health Recovery Training Modules

Personnel from the Regional Human Service Centers, Recovery Centers, Private Providers and Consumers are asked to complete the training modules to promote understanding and implementation of recovery-oriented person-centered behavioral health services throughout the state.

Consumer Family Network

The Division of Mental Health and Substance Abuse Services contracts with Mental Health American of North Dakota to implement the Consumer and Family Network (CFN). The CFN structure consists of a Coordinating Center, a CFN Collaborative, as well as a CFN Council.

The overall goals of the CFN are the empowerment of consumers to be well-informed of their choices and possibilities beyond those presently available, and for behaviors health care to be consumer and family driven. The CFN advocates for consumer involvement at all levels of policy planning and program development, implementation, and evaluation. Meaningful involvement of consumers in the behavioral health system can ensure they lead a self-determined life in the community. The CFN supports a strong consumer base of advocacy and self-promotion and a high degree of collaboration amongst consumers and family members and within the existing mental health advocacy organizations, and extends beyond to include partnerships with funder and providers of behavioral health care.

Annual Consumer and Family Network Conference

This annual conference is funded, planned and implemented by the Consumer and Family Network.

Recovery Treatment Mall

The ND State Hospital implements the Treatment Mall, which is a recovery-focused alternative to the traditional inpatient model. The program establishes a structure of treatment that would naturally follow the consumer when living independently. The Treatment Mall consists of a full array of groups and learning experiences that consumers select based on their needs and interests. Individuals work with a coordinator and a treatment team to define a life goal through a Recovery Plan. The individual then chooses classes that will help develop the skills that will move them towards their goals.

North Dakota Recovery Council

The Recovery Council was implemented in June, 2007. The purpose of the Council is to build a "Recovery Community" to enhance Recovery-Based services and supports for individuals following the formal treatment experience, to promote Recovery throughout the state, and to address the stigma associated with substance abuse. Membership includes Consumers, Division of Mental Health and Substance Abuse, Regional Human Service Center, Faith Based Community, Private Treatment Agencies, Tribal entities, Prevention Coordinators, Recoveree Connection, Probation and Parole.

Telephone Recovery Support

The "Recoveree Connection", North Dakota's Telephone Recovery Support Program, was implemented statewide in June, 2008. The Department of Human Services contracts with Rehab Services, a private agency located in Minot, North Dakota to administer the program. The Recoveree Connection is a non-clinical, volunteer based, support service whereby individuals in recovery from substance use disorders receive telephone calls from trained telephone recovery support specialists, most of whom are peers in the process of recovering themselves. Volunteers provide a "check-in" with the person in the early stages of recovery and help the individual to access community supports that further support the person's recovery in the community.

Peer To Peer Support

Peer Support Programs are located at each of the 8 Regional Recovery Centers, as well as the North Dakota State Hospital. Peer Support Services are consumer centered with rehabilitation and recovery focus designed to promote skills for coping with and managing symptoms while facilitating the utilization of natural resources and the enhancement of community living skills. Peer Support Services are provided by a person who has progressed in their own mental health recovery and is working to assist other people with mental health issues. Because of their life experience, peers have expertise that professional training cannot replicate. Peer Specialists foster their peer's ability to make informed, independent choices; help their peers recognize,

and build on their strengths; and help their peers get the information and support they need from the community to make their goals a reality. Peer Specialists perform a wide range of tasks to assist peers in attaining their recovery goals. Peer Specialists undergo certification training and complete the certification process developed and recognized by the ND DHS.

The DMHSA hired a Peer Support Coordinator who oversees the Peer Support Programs across the state. This person is scheduled to attend Wellness Recovery Action Plan (WRAP) Training and will provide the information obtained to the 8 Regional Programs to enhance the utilization of WRAP across the state.

Person-Centered Treatment Planning

In an effort to improve documentation of medical necessity and help move the community-based public mental health system more toward person-centered care, the Department requested technical assistance from the National Technical Assistance Center. Dr. Neal Adams, Diane Grieder, and Dr. Ed Diksa were consulted concerning implementation of Treatment Planning for Person-Centered Care. This model was chosen because it not only represents a growing and increasingly respected place in the national behavioral health care arena, but it also allows for the blending of valuing consumer strengths and goals while retaining recognition of the importance of good diagnosing and planning for the measurable clinical outcomes that reduce or resolve clinical barriers to consumer recovery. Fifty-nine staff from the regional human service centers received one-and-one-half days of preliminary training in this model. Phase 2 of the project consisted of training 24 human service center staff members as trainers of the model. This training was held in mid July of 2008. The trainers then returned to their human service center and began working with consumers on their caseloads to develop person centered treatment plans, with the continued consultation and guidance from the TA consultants. They also began training staff within the center on the practice. Phase III of the project has been the continuation and broadening of the activities of Phase II. Included have been training more clinicians on the model and modifying the Department's electronic record to aide in development of person-centered treatment plans and documenting medical necessity. Planning for Phase IV, which will occur during the upcoming fiscal year, is underway and will include further clinician and supervisor training as additional enhancements to the electronic record.

NDAC 75-09.1 requires substance abuse treatment programs to include in client records evidence of the direct involvement of the client in the decision-making process related to the client's program.

State rules prescribe standards for care plans for adults with serious mental illnesses who are served by a human service center (N.D.A.C. 75-05-04-03). The rules require that each individual have a plan, the overall development and implementation of which "are the responsibility of the professional staff member assigned the client". Furthermore, "The professional staff member assigned to the consumer shall develop and review the individual plan with the consumer, shall document in the consumer's record the consumer's input in the development and review indicating the extent of the involvement in developing the individual plan, and shall have the consumer sign the treatment plan." A plan "must contain the client's

name, problems, service strategies to resolve problems, goals, names of staff members responsible for service strategies, and the signature of the case manager". "The professional staff member assigned the client shall review the individual plan with the client and shall document the review in the client's record". For "clinical services, the consumer, case manager, and case manager's supervisor shall review individual plans at least every six months, except when consumer circumstances necessitate a change to the treatment plan."

Training on stages of change and stages of treatment serves to compliment the work we are doing on person-centered treatment planning. Recognizing the importance of meeting the consumer where they are at, developing an open trusting relationship, and engaging consumers in their own care is critical to successful outcomes for consumers. The substance abuse unit at Southeast Human Service Center participated in a one day training session in May 2010. A four session on the training was offered at the 2011 Clinical Forum on Mental Health Conference. Staff from the regional human service centers, State Hospital, and various community providers were in attendance at that session. Clinicians providing services at the regional human service centers are beginning to complete a more formal "staging' of consumers as they work closely with them to develop treatment plans.

IV: Narrative Plan

M. Use of Technology

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Narrative Question:

Interactive Communication Technologies (ICTs) are being more frequently used to deliver various health care services. ICTs are also being used by individuals to report health information and outcomes. ICT include but are not limited to: text messaging, etherapy, remote monitoring of location, outreach, recovery tools, emotional support, prompts, case manager support and guidance, telemedicine. In the space below, please describe:

a. What strategies has the State deployed to support recovery in ways that leverage Interactive Communication Technology?
b. What specific applications of ICTs does the State plan to promote over the next two years?
c. What incentives is the State planning to put in place to encourage their use?
d. What support systems does the State plan to provide to encourage their use?
e. Are there barriers to implementing these strategies? Are there barriers to wide-scale adoption of these technologies and how does the State plan to address them?
f. How does the State plan to work with organizations such as FQHCs, hospitals, community-based organizations and other local service providers to identify ways ICTs can support the integration of mental health services and addiction treatment with primary care and emergency medicine?
g. Will the State use ICTs for collecting data for program evaluation at both the client and provider levels?
h. What measures and data collection will the State promote for promoting and judging use and effectiveness of such ICTs?

Footnotes:

USE OF TECHNOLOGY

a. What strategies has the State deployed to support recovery in ways that leverage Interactive Communication Technology?

Telemedicine

A survey was completed to assess the comfort level of consumers and their use of ICT. Research on other states' activities was completed and a basic protocol was established. The regional human service centers began the use of telemed contract in areas of psychiatrist shortage. One regional human service center, NEHSC, piloted acute therapy service via contract with a FCHS, Northwood. -ND Medical Assistance approved reimbursement for psychiatric evaluation and medication reviews. A second polycom location was installed at each regional human service center to accommodate additional use of ICT. The state Information Technology Department (ITD) researched and implemented the hosting of a new platform with increased connectivity (desktop to desktop, laptop to desktop, etc.) Work was completed on infrastructure details which included implementation into the EHR, billing, scheduling, and support functions. A regional human service center, LRHSC, began providing more telemed services due to flooding/road access issues. The Department's Medical Director, Dr. McLean, implemented telemed services to areas of need (direct patient services as well as CNS supervision). Preparation was done to prepare DHS physicians for increased involvement. Polycom is used for Department of Corrections & Rehabilitation (DOCR) release & integration planning with inmates.

Telepharmacy

Regional HSC clients now receive prescriptions from DHS physicians or primary care physicians using telepharmacy support. Because of the new medications, increased complexity is common and use of telepharmacy assists with immediate support and education on medication. A new pharmacy position was added at the NDSH for telepharmacy. This was approved by 2011 legislature. More medication programs have resulted in concerns regarding administering vs. dispensing medications. The Department's Medical Director, Dr. McLean, worked with Pharmacy Board to clarify roles/functions/requirements. Training needs for HSC staff were identified. Both the regional HSC and the NDSH have steering committees.

Telephone Recovery Support – a contract is in place that uses telephone support for those in recovery from SUD. This allows those in isolated areas and those who do not wish to participate in traditional support groups, to obtain support via trained recovery support staff.

b. What specific application of ICTs does the State plan to promote over the next two years?

Research is occurring on other services delivered via telemedicine and their related codes that Medicaid would be willing to reimburse. The plan is to expand to these additional codes in 2012. Expansion would include adding psychiatrists and more locations to the use of telemedicine.

c. What incentives is the State planning to put in place to encourage their use?

Unknown

d. What support system does the State plan to provide to encourage their use?

Unknown

e. Are there barriers to implementing these strategies? Are there barriers to wide-scale adoption of these technologies and how does the State plan to address them?

Social media and risk analysis is needed. Policy and procedures are needed to safely implement their use by staf.

f. How does the State plan to work with organizations such as FQHCs, hospitals, community-based organizations and other local service providers to identify ways ICTs can support the integration of mental health services and addiction treatment with primary care and emergency medicine?

As this has already begun, continued evolution of this method plus integration of new technology gains.

g. Will the State use ICTs for collecting data for program evaluation at both the client and provider levels?

Unknown but being considered.

h. What measures and data collection will the State promote for promoting and judging use and effectiveness of such ICTs?
Number of services codes reimbursed for delivery by this method.

Telemedicine/Telepharmacy Update
April 2011

	TELEMEDICINE	TELEPHARMACY
	-1990's: NDSH patient court	-HSC clients receive prescriptions

HISTORY	hearings via polycom Surveyed consumers to assure comfort level -Researched other states' activities and established basic protocol -HSCs began telemed contract in areas of psychiatrist shortage -NEHSC and Northwood FQHC piloted some acute therapy services via contract -ND Medical Assistance approved for psychiatric eval and medication review (t code for location) -2nd polycoms placed in all HSCs	from DHS physicians or primary care physicians; -Clients use local pharmacies and/or sample meds provided to HSCs -Staff assist in filling med boxes etc. -More clients reside in the community with higher volume of medication activities -More/new medications = more complexity -HSCs have flexibly used nursing staff in this function
CURRENT ACTIVITIES	-ITD researched and hosts a new platform with increased connectivity (desktop to desktop, laptop to desktop, etc.) -Working on infrastructure details: ROAP id's, billing, scheduling, support functions -LRHSC providing more telemed services due to flooding/road access issues -Dr. McLean implementing telemed services to areas of need (direct patient services as well as CNS supervision) -Preparing DHS physicians for increased involvement -Use polycom for DOCR release & integration planning with inmates -HSCs share Title XIX authorizations across centers; will increase use of telemed for these	-New pharmacy FTE at NDSH for telepharmacy approved by 2011 legislature -More med programs have resulted in concerns regarding administering vs. dispensing medications -Dr. McLean worked with Pharmacy Board to clarify roles/functions/requirements -Training needs for HSC staff identified -HSC and NDSH have steering committee for work on planning and infrastructure
	-Maggie and Nancy to determine other services approved for t location code -Expand rollout in 2011-2013	-NDSH pharmacy to provide oversight of med dispensing in HSCs -Requires visual review of

FUTURE EXPECTATIONS	to include more psychiatrists and more sites -Technology continues to improve -Younger staff and clients more comfortable with technology -Will increase options to improve access without travel -NDSH exploring potential to provide consultative services to rural access hospitals	medication by the pharmacist -Includes client education and documentation of that service -HSC nurses to receive training in required courses through Lake Region College -SCHSC to be first pilot site, target date by January 2012 -Roll out to all HSCs in 2011-2013 biennium

IV: Narrative Plan

N. Support of State Partners

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Narrative Question:

The success of a State's MHBG and SABG will rely heavily on the strategic partnership that SMHAs and SSAs have or will develop with other health, social services, education and other State and local governmental entities. States should identify these partners in the space below and describe the roles they will play in assisting the State to implement the priorities identified in the plan. In addition, the State should provide a letter of support indicating agreement with the description of their role and collaboration with the SSA and/or SMHA, including the State education authority(ies); the State Medicaid agency; the State entity(ies) responsible for health insurance and health information exchanges (if applicable); the State adult and juvenile correctional authority(ies); the State public health authority, (including the maternal and child health agency); and the State child welfare agency. SAMHSA will provide technical assistance and support for SMHAs and SSAs in their efforts to obtain this collaboration. These letters should provide specific activities that the partner will undertake to assist the SMHA or SSA with implanting its plan. This could include, but is not limited to:

- The State Medicaid Agency agreeing to consult with the SMHA or the SSA in the development and/or oversight of health homes for individuals with chronic health conditions or consultation on the benefits available to the expanded Medicaid population.
- The State Department of Justice that will work with the State and local judicial system to develop policies and programs that address the needs of individuals with mental and substance use disorders that come into contact with the criminal and juvenile justice systems; promote strategies for appropriate diversion and alternatives to incarceration; provide screening and treatment; and implement transition services for those individuals reentering the community.
- The State Education Agency examining current regulations, policies, programs, and key data-points in local school districts to ensure that children are safe; supported in their social-emotional development; exposed to initiatives that target risk and protective actors for mental and substance use disorders; and, for those youth with or at-risk of emotional behavioral and substance use disorders, to ensure that they have the services and supports needed to succeed in school and improve their graduation rates and reduce out-of-district placements.
- The State Child Welfare/Human Services Department, in response to State Child and Family Services Reviews, working with local child welfare agencies to address the trauma, and mental and substance use disorders in these families that often put their children at-risk for maltreatment and subsequent out-of-home placement and involvement with the foster care system.

Footnotes:

SUPPORT OF STATE PARTNERS

The North Dakota Mental Health Planning Council's membership includes representatives from Medicaid, the North Dakota Housing Finance Agency, social services, mental health, the North Dakota Department of Correction and Rehabilitation, Vocational Rehabilitation, the North Dakota Indian Affairs Commission, Aging Services, and the North Dakota Department of Public Instruction. They are highly involved with the planning for the community-based public behavioral health system and actively participate in the quarterly meetings of the Council. Because of this, the Council's letter – which will become a part of this application – serves as notice of their support.

The Governor's Prevention Advisory Council (GPAC) on Drugs and Alcohol was created by Executive Order 2007-03 in May 2007 and is chaired by the Single State Authority for Substance Abuse Services. The Council recognizes that preventative behavior reduces adverse personal, social, health and economic consequences resulting from destructive decisions and that prevention efforts foster safe and healthy environments for individuals, families and communities in North Dakota. The GPAC is the advisory group for the North Dakota SPF-SIG grant. The following agencies/organizations are represented on the GPAC: community advocacy groups, substance abuse treatment, youth organization, North Dakota University System, Department of Human Services, Department of Health, Department of Transportation, and the Governor's Office.

IV: Narrative Plan

O. State Behavioral Health Advisory Council

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Narrative Question:

Each State is required to establish and maintain a State advisory council for services for individuals with a mental disorder. SAMHSA strongly encourages States to expand and use the same council to advise and consult regarding issues and services for persons with or at risk of substance abuse and substance use disorders as well. In addition to the duties specified under the MHBG, a primary duty of this newly formed behavioral health advisory council would be to advise, consult with and make recommendations to SMHAs and SSAs regarding their activities. The council must participate in the development of the Mental Health Block Grant State plan and is encouraged to participate in monitoring, reviewing and evaluating the adequacy of services for individuals with substance abuse disorders as well as individuals with mental disorders within the State.

Please complete the following forms regarding the membership of your State's advisory council. The first form is a list of the Advisory Council for your State. The second form is a description of each member of the behavioral health advisory council.

Footnotes:

STATE BEHAVIORAL HEALTH ADVISORY COUNCIL

What planning mechanism does your State use to plan and implement substance abuse services?

The Department holds biennial stakeholder meetings. These stakeholder meetings are held at each regional human service center and each community plus the two state institutions – Developmental Center and North Dakota State Hospital. The meetings provide opportunity for input on services delivered by the Department. Comments are also taken in writing.

There is discussion being held by the MH Planning council on transitioning to a Behavioral Health council. This idea has been met with positive reaction and comments. Analysis into the membership will take place to allow for the inclusion of SUD and prevention.

Quarterly meetings are held with AOD supervisors to gain perspective from the field on service needs, challenges, and barriers. Consumer satisfaction surveys are completed annually and specific addiction and mental health sections are identified in order to target planning efforts. The state recovery council holds meetings quarterly and its charge is to pursue expansion of recovery supports for those with SUD.

• How do these efforts coordinate with the State mental health agency and its Advisory body for substance abuse prevention and treatment services?

The Department of Human Services is an umbrella agency and the Division has integrated the mental health and substance abuse functions. Given this landscape, many planning efforts are already coordinated and integrated. The Advisory body's intent on evolving into a behavioral health council will be complimentary to the approach and design already in place.

IV: Narrative Plan

Table 11 List of Advisory Council Members

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Start Year:

End Year:

Name	Type of Membership	Agency or Organization Represented	Address, Phone, and Fax	Email (if available)
Maggie Anderson	State Employees	North Dakota Department of Human Services	600 East Boulevard Avenue, Dept. 325 Bismarck, ND 58505 PH: 701-328-1603 FAX: 701-328-1544	manderson@nd.gov
Michael Anderson	State Employees	North Dakota Housing Finance Agency	2624 Vermont Avenue, PO Box 1535 Bismarck, ND 58502-1535 PH: 701-328-8050 FAX: 701-328-8090	maanders@ndhfa.org
Russ Cusack	State Employees	North Dakota Department of Human Services	1237 West Divide Avenue, Suite 1A Bismarck, ND 58501 PH: 701-328-8926 FAX: 701-328-8969	rcusac@nd.gov
Scott Davis	State Employees	North Dakota Indian Affairs Commission	600 East Boulevard Avenue, Room #117 Bismarck, ND 58505 PH: 701-328-2428 FAX: 701-328-1537	
			1524 Sundance	

Tom Fischer	Others (Not State employees or providers)	North Dakota State Legislature	Square South Fargo, ND 58104 PH: 701-293-1700	tfischer@nd.gov
Ken Gerhardt	State Employees	Morton County Social Services	200 2nd Avenue Mandan, ND 58554 PH: 701-667-3395 FAX: 701-667-3384	kenneth.gerhardt@mortonnd.gov
Sheri Haugen -Hoffart	Others (Not State employees or providers)		9200 33rd Street, SE Bismarck, ND 58504 PH: 701-224-5403	sheri.haugen.hoffart@email.und.edu
Susan Helgeland	Others (Not State employees or providers)	Mental Health America of North Dakota	PO Box 4106 Bismarck, ND 58502-4106 PH: 701-255-3692	srhelgeland@gmail.com
Sara Highum	Individuals in Recovery (from Mental Illness and Addictions)		812 10th Street NW Minot, ND 58703 PH: 701-839-8335	shighum@srt.com
Rick Hoekstra	State Employees	North Dakota Department of Corrections and Rehabilitation	PO Box 5521 Bismarck, ND 58506-5521 PH: 701-328-6699 FAX: 701-328-6186	rhoekstr@nd.gov
JoAnne Hoesel	State Employees	North Dakota Department of Human Services	1237 West Divide Avenue, Suite 1C Bismarck, ND 58501 PH: 701-328-8924 FAX: 701-328-8969	jhoesel@nd.gov
Deb Jendro	Individuals in Recovery (from Mental Illness and Addictions)		2709 Elm Street Fargo, ND 58102 PH: 701-235-9923 FAX: 701-235-9923	debjfederation@yahoo.com
			930 N. 3rd Street	

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Debra Johnson	Family Members of Individuals in Recovery (from Mental Illness and Addictions)		Grand Forks, ND 58203 PH: 701-795-9143 FAX: 701-772-5560	djohnsonphf@yahoo.com
Diane Kleven	Family Members of Individuals in Recovery (from Mental Illness and Addictions)		1043 2nd Street W. West Fargo, ND 58078 PH: 701-282-4853	datachsr51@far.midco.net
Teresa Larsen	Others (Not State employees or providers)	Protection and Advocacy Project of North Dakota	400 East Broadway, Suite 409 Bismarck, ND 58501 PH: 701-328-2950 FAX: 701-328-3934	tlarsen@nd.gov
Carlotta McCleary	Others (Not State employees or providers)	ND Federation of Families for Children's Mental Health	PO Box 3061 Bismarck, ND 58502 PH: 701-222-3310 FAX: 701-222-3310	carlottamccleary@bis.midco.net
Karen Quick	State Employees	Northwest Human Service Center	316 2nd Avenue W., Box 1266 Williston, ND 58802 PH: 701-774-4685 FAX: 701-774-4620	kquick@nd.gov
Becky Sevart	Others (Not State employees or providers)		PO Box 3061 Bismarck, ND 58502 PH: 701-258-1628 FAX: 701-258-1628	bsevart@bis.midco.net
Steve McWilliams	Individuals in Recovery (from Mental Illness and Addictions)		310 2nd Street SE, #1513 Minot, ND 58701 PH: 701-833-2195	steve.minot.2002@gmail.com
Missi Baranko	Family Members of Individuals in Recovery (from Mental Illness and Addictions)		2123 Highway 85 Belfield, ND 58622 PH: 701-290-8711	missi.baranko@gmail.com

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Jodi Stittsworth	Family Members of Individuals in Recovery (from Mental Illness and Addictions)		739 Great Plains Ct Grand Forks, ND 58201 PH: 701-610-1724	jodi1510@hotmail.com
Sandra Tibke	State Employees	North Dakota Department of Public Instruction	600 East Boulevard Avenue Bismarck, ND 58505 PH: 701-328-2260	

Footnotes:

IV: Narrative Plan

Table 12 Behavioral Health Advisory Council Composition by Type of Member

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Start Year:

End Year:

Type of Membership	Number	Percentage
Total Membership	27	
Individuals in Recovery (from Mental Illness and Addictions)	3	
Family Members of Individuals in Recovery (from Mental Illness and Addictions)	4	
Vacancies (Individuals and Family Members)	5	
Others (Not State employees or providers)	6	
Total Individuals in Recovery, Family Members & Others	18	66.67%
State Employees	9	
Providers	0	
Leading State Experts	0	
Federally Recognized Tribe Representatives	0	
Vacancies	0	
Total State Employees & Providers	9	33.33%

Footnotes:

IV: Narrative Plan

P. Comment On The State Plan

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Narrative Question:

SAMHSA statute requires that, as a condition of the funding agreement for the grant, States will provide opportunity for the public to comment on the State plan. States should make the plan public in such a manner as to facilitate comment from any person (including Federal or other public agencies) during the development of the plan (including any revisions) and after the submission of the plan to the Secretary. In the section below, States should describe their efforts and procedures to obtain public comment on the plan in this section.

Footnotes:

COMMENT ON THE STATE PLAN

The state requested and received approval for an extension for the public comment period. This is due to the short amount of time between the final Block Grant Application being posted in the Federal Register and when the application is due and President Obama issuing a disaster declaration for the state of North Dakota May 10th followed by an individual assistance declaration on June 24, 2011. This disaster declaration has required the Division to put resources into writing the immediate and regular services crisis counseling grants in addition to writing the block grant with its new requirements.

North Dakota will not be able to provide the plan for public comment prior to submission of the application on September 1, 2011. In accordance with the SAMHSA directive on May 24, 2011 (accessed at http://www.samhsa.gov/grants/blockgrant/BG_FAQS_05-24-11.pdf), North Dakota provides the following plan for completion of this requirement: On September 1, 2011, the application will be placed on the Department of Human Services' website for review by the public. Comments will be taken until September 30, 2011. Comments will then be compiled and forwarded to SAMHSA. The application will remain on the Department's website until such time that a new Combined Behavioral Health Assessment and Plan is drafted. Public comment will be accepted at anytime and forwarded to SAMHSA.

Development of the North Dakota Suicide Prevention Coalition Strategic Plan

Pat Conway, Ph.D, LCSW
Senior Research Scientist

February 25, 2011

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North Dakota Suicide Prevention Coalition Strategic Planning, 2010-2015

The ND Suicide Prevention Coalition, with support from the ND Department of Health Division of Injury Prevention's Garrett Lee Smith youth suicide prevention grant, developed a strategic plan in 2009-2010. The Coalition, which met four times November 2009-August 2010, completed a SWOT analysis and developed goals and objectives, to complete the North Dakota Suicide Prevention Coalition Strategic Plan. Two Coalition workgroups, focusing on 1) Prevention Strategies and 2) Infrastructure, met between the Coalition meetings. The coalition activities resulted in an initial plan and structure for the Coalition for the next five years.

Method for Development of the Strategic Plan. The objectives for the Coalition's strategic planning were:

1. Renewed collaboration to achieve prevention of suicide and risk factors for suicide in North Dakota.
2. Identification of factors to consider when selecting prevention strategies
3. Determination of strategies to use to prevent suicide
4. Determination of Coalition role
   a) strengths/opportunities
   b) weaknesses/threats
   c) Coalition structure to implement strategies

The process of strategic planning began with a review of relevant background information, brainstorming strengths and weaknesses, development of the role of the Coalition, and creation of goals and objectives (see Figure 1.2). A modified SWOT process was employed, including strengths and weaknesses of the Coalition and opportunities and threats in the environment. Coalition members agreed to employ diverse, inclusive methods of working during the brainstorming and decision making sessions.

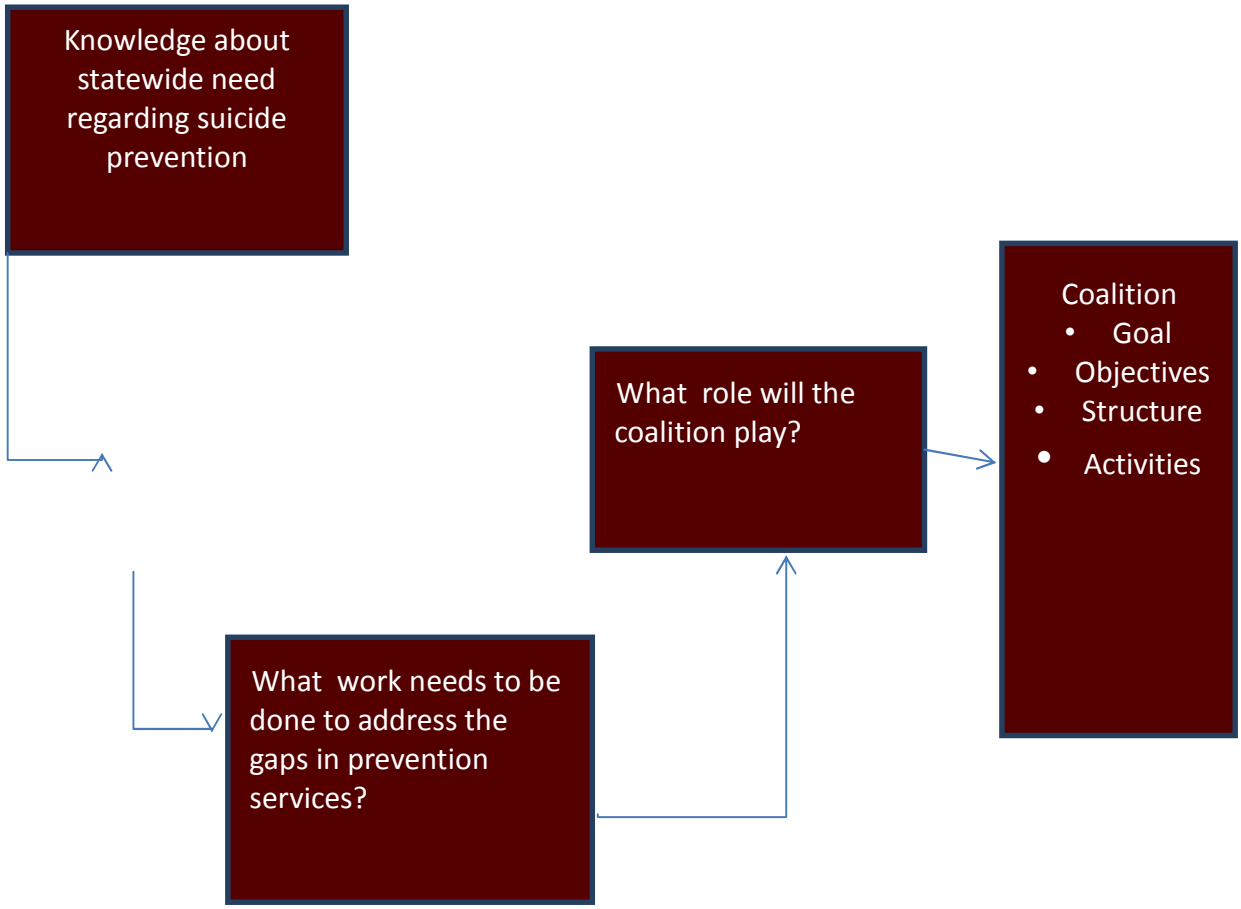


Figure 1.2. *Map for Strategic Planning*

To develop the strategic plan, the Coalition members completed a SWOT analysis at the November 2009 meeting. They received information about the history of the coalition, statistics regarding suicide in North Dakota, and national resources including national goals and objectives. Using these materials, Coalition members brainstormed strengths and gaps within the Coalition and opportunities and threats in the environment. Following the November 2009 meeting, a small group summarized the goals and objectives that resulted of the SWOT analysis. They were sent to the Coalition through an electronic survey, to rank the list of potential goals and objectives. An initial strategic planning report was sent to Coalition members January 11, 2010. One comment in the report described the importance of the process to Coalition members:

> I am very impressed with these objectives and goals. I do feel it is most important to get suicide prevention, especially through the coalition, into the media.

The next Coalition meeting, held February 3, 2010, 10 am to 1 pm, in Bismarck and through video conferencing at Spirit Lake and Fargo, 15 members reviewed the results of the survey and identified two goals and a plan for refining the objectives, through two workgroups. At the final meeting, August 4, 2010, the Coalition approved initial infrastructure plans, elected officers, and set in motion a method for fleshing out the activities to initiate the Coalition strategic plan.

***Assumptions Guiding This Planning Process*.** Five assumptions guided the strategic planning process:

- Based on Public Health Prevention Model (see Figure 1.3)
- Values evidence-based strategies
- Culturally appropriate
- Based on National Strategy for Suicide Prevention
- Statewide

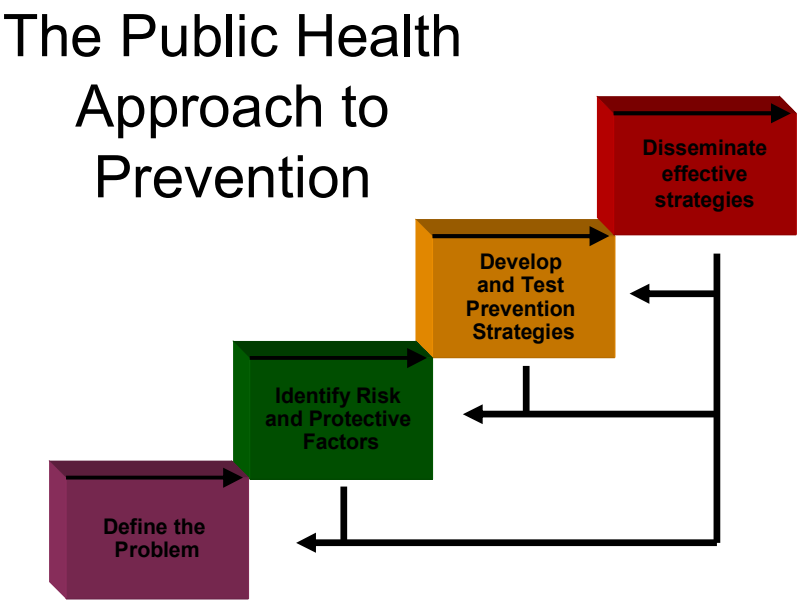


Figure 1.3. The Public Health Approach

The Coalition's intent is to make the Coalition a part of the State Suicide Prevention Plan, creating a goal within the State Plan for the Coalition. The Coalition will create their workplan, with objectives, activities and strategies, and a timeframe. Definitions guiding the development of goals and objectives were:

> GOAL: A goal is a broad and high-level statement of general purpose to guide planning around an issue. It is focused on the end result of the work.

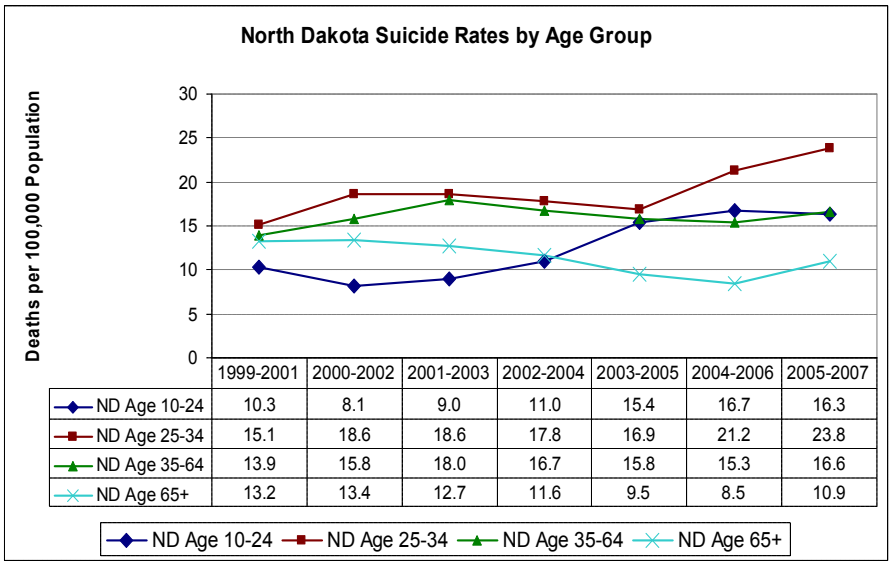
OBJECTIVE: An objective narrows the goal by specifying the who, what, when and where associated with obtaining the goal or clarifies by how much, how many, or how often. Ideally, an objective offers measurable milestones or targets and is very specific–it clearly identifies what is to be achieved.

Strengths, Need, Threats, and Opportunities to Accomplish the Coalition's Mission. At the November 2009 Coalition Meeting, Coalition members reviewed data regarding magnitude of the problem, factors that contribute to suicide, and national goals and objectives. They then brainstormed strengths and need of the Coalition and threats and opportunities in the environment.

Information Reviewed to Guide the SWOT Analysis. *Magnitude of the Problem in North Dakota***.** The North Dakota Department of Health and the Medical Examiner's Office reviewed statistics regarding deaths by suicide in North Dakota between 1997 and 2005. The average age of persons completing suicide was 42 (see Table 1.3, Figure 1.4). More were males. The percent of persons who died by suicide who were American Indian (12%) was much higher than the percent of American Indians in the general population (5.6%).

Table 1.3. *1997-2005 Suicide in North Dakota*

707 ND resident suicides during the years 1997 through 2005
Average Age – 42 years
Gender – Male 84%, Female 16%
Race – White 87%, American Indian 12%, Other 1%
Veteran – 23% (30% of veteran suicides are age 65 and older) (ND Department of Health, Vital Records and Medical Examiner's Office)



	1999-2001	2000-2002	2001-2003	2002-2004	2003-2005	2004-2006	2005-2007
ND Age 10-24	10.3	8.1	9.0	11.0	15.4	16.7	16.3
ND Age 25-34	15.1	18.6	18.6	17.8	16.9	21.2	23.8
ND Age 35-64	13.9	15.8	18.0	16.7	15.8	15.3	16.6
ND Age 65+	13.2	13.4	12.7	11.6	9.5	8.5	10.9

Figure 1.4. Suicide Rates by Age Group

Actual data for 2008 indicate that, for that year, the number of deaths by suicide occurred almost equally across all age groups up to age 65 (see Table 1.4). Persons ages 55-64 had the highest

rate per 100,000. (Note. This reflects one year's data only, which may look different from year to year because of small numbers.)

Table 1.4. *Actual Numbers for 2008*

Age Group	Number	Rate Per 100,000
Under 10	0	0.0
10-24	16	10.6
25-34	16	20.8
35-44	17	17.3
45-54	15	17.6
55-64	16	29.9
65+	6	6.4
Total	86	13.4

Rural communities, including Benson, Eddy, Dunn, Burke, and Sioux counties have the highest suicide rates (see Figure 1.5).

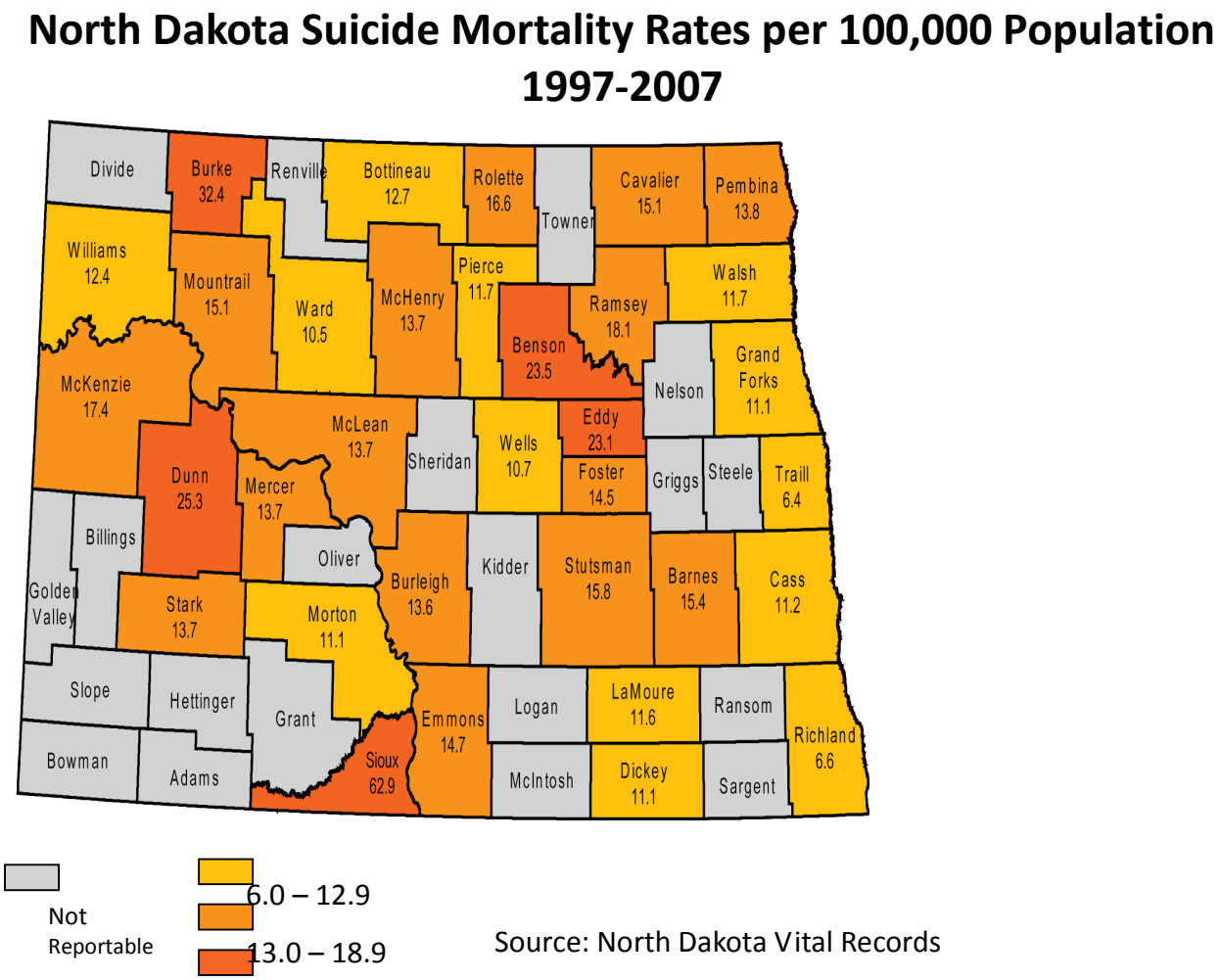


Figure 1.5. Suicide Rates by County

Risk Factors for Suicide and Suicidal Behavior. To facilitate planning, data regarding risk factors for suicide and suicidal behavior at the national and state level were reviewed. Risk factors include individual (genetic and environmental factors including medical and mental disorders, access to lethal means, and the presence of a crisis (http://www.suicidology.org/web/guest/stats-and-tools/fact-sheets). Of these, the Coalition reviewed depression, the method of death, and drugs and alcohol.

Depression. Depression is a chronic illness that exacts a significant toll on America's health and productivity. This illness is the leading cause of disability in the United States for individuals ages 15 to 44 (World Health Organization, 2004). Lost productive time among U.S. workers due to depression is estimated to be in excess of $31 billion per year (Steward et al., 2003). Depression frequently co-occurs with a variety of medical illnesses such as heart disease, cancer, and chronic pain and is associated with poorer health status and prognosis (Munce, 2007; Blumenthal et al., 2007, Moussavi, 2007). Depression is a risk factor for suicide (Currier and Mann, 2008). Each year, roughly 30,000 Americans take their lives, while hundreds of thousands make suicide attempts (Centers for Disease Control and Prevention). In 2004, suicide was the 11th leading cause of death in the United States (Centers for Disease Control and Prevention), third among individuals 15-24 (Mark, Shern, Bagalman, & Cao, 2007, p. iii).

Common Methods of Suicide in North Dakota. In North Dakota, the most common method of death by suicide is with firearms (see Table 1.5).

Table 1.5. *Method of Death*

Method	N	%
Firearms	397	56.2
Hanging	157	22.2
Drugs/Poisons	110	15.6
Other	43	6.1
Total	707	100.0

Correlation between Drugs and Alcohol and Suicide. The North Dakota coroner's office completed a study of the relationship between drugs and alcohol and suicide in North Dakota, reviewing death records. In the approximately 700 cases reviewed, the Blood Alcohol Count (BAC) had been conducted in 58% (409) of the cases. Of those who had a BAC, <47% had some level of alcohol; 33% had a BAC >= .08. A Drug Screen (DS) was conducted in 57% (401) cases. Of those where a DS was conducted, 32% had some type of drug (130), most frequently mixed prescription (38%) or marijuana (26%). (ND Department of Health, Vital Records and Medical Examiner's Office)

A Model for Goals and Objectives for the ND Suicide Prevention Plan: The National Strategy for Suicide Prevention: Goals and Objectives for Action. To provide guidance for the development of goals and objectives for the North Dakota Suicide Prevention Project, the National Strategy for Suicide Prevention's goals were reviewed.

Goal 1: Promote Awareness that Suicide is a Public Health Problem that is Preventable.

- Prevent premature deaths due to suicide across the life span
- Reduce the rates of other suicidal behaviors

- Reduce the harmful after-effects associated with suicidal behaviors and the traumatic impact of suicide on family and friends
- Promote opportunities and settings to enhance resiliency, resourcefulness, respect, and interconnectedness for individuals, families, and communities

Goal 2: Develop Broad-based Support for Suicide Prevention.

- Organizing a Federal interagency committee to improve coordination and to ensure implementation of the National Strategy
- Establishing public/private partnerships dedicated to implementing the National Strategy
- Increasing the number of professional, volunteer, and other groups that integrate suicide prevention activities into their ongoing activities, and
- Increasing the number of faith communities that adopt policies designed to prevent suicide.

Goal 3: Develop and Implement Strategies to Reduce the Stigma Associated with Being a Consumer of Mental Health, Substance Abuse, and Suicide Prevention Services

- Increasing the number of suicidal persons with underlying mental disorders who receive appropriate mental health treatment
- Transforming public attitudes to view mental and substance use disorders as real illnesses, equal to physical illness, that respond to specific treatments and to view persons who obtain treatment as pursuing basic health care.

Goal 4: Develop and Implement Suicide Prevention Programs

- Increasing the proportion of States with comprehensive suicide prevention plans
- Increasing the number of evidence-based suicide prevention programs in schools, colleges and universities, work sites, correctional institutions
- aging programs, and family, youth, and community service programs
- Developing technical support centers to build the capacity across the States to implement and evaluate suicide prevention programs.

Goal 5: Promote Efforts to Reduce Access to Lethal Means and Methods of Self-Harm

- Educating health care providers and health and safety officials on the assessment of lethal means in the home and actions to reduce suicide risk
- Implementing a public information campaign designed to reduce accessibility of lethal means
- Improving firearm safety design, establishing safer methods for dispensing potentially lethal quantities of medications and seeking methods for reducing carbon monoxide poisoning from automobile exhaust systems
- Supporting the discovery of new technologies to prevent suicide.

Goal 6: Implement Training for Recognition of At-Risk Behavior and Delivery of Effective Treatment

- Improving education for nurses, physician assistants, physicians, social workers, psychologists, and other counselors
- Providing training for clergy, teachers and other educational staff, correctional workers, and attorneys on how to identify and respond to persons at risk for suicide
- Providing educational programs for family members of persons at elevated risk.

Goal 7: Develop and Promote Effective Clinical and Professional Practices

- Changing procedures and/or policies in certain settings, including hospital emergency departments, substance abuse treatment centers, specialty mental health treatment centers, and various institutional treatment settings,
- designed to assess suicide risk
- Incorporating suicide-risk screening in primary care
- Ensuring that individuals who typically provide services to suicide survivors have been trained to understand and respond appropriately to their unique needs (e.g., emergency medical technicians, firefighters, police, funeral directors)
- Increasing the numbers of persons with mood disorders who receive and maintain treatment
- Ensuring that persons treated for trauma, sexual assault, or physical abuse in emergency departments receive mental health services
- Fostering the education of family members and significant others of persons receiving care for the treatment of mental health and substance abuse disorders with risk of suicide.

Goal 8: Improve Access to and Community Linkages with Mental Health and Substance Abuse Services

- Increasing the number of States that require health insurance plans to cover mental health and substance abuse care on par with coverage for physical health care
- Implementing utilization management guidelines for suicidal risk in managed care and insurance plans
- Integrating mental health and suicide prevention into health and social services outreach programs for at-risk populations
- Defining and implementing screening guidelines for schools, colleges, and correctional institutions, along with guidelines on linkages with service providers
- Implementing support programs for persons who have survived the suicide of someone close.

Goal 9: Improve Reporting and Portrayals of Suicidal Behavior, Mental Illness, and Substance Abuse in the Entertainment and News Media

- Establishing a public/private group designed to promote the responsible representation of suicidal behaviors and mental illness on television and in movies
- Increasing the number of television programs, movies, and news reports that observe recommended guidelines in the depiction of suicide and mental illness,

- Increasing the number of journalism schools that adequately address reporting of mental illness and suicide in their curricula.

Goal 10: Promote and Support Research on Suicide and Suicide Prevention

- Developing a national suicide research agenda
- Increasing funds for suicide prevention research
- Evaluating preventive interventions
- Establishing a registry of interventions with demonstrated effectiveness for prevention of suicide or suicidal behavior.

Goal 11: Improve and Expand Surveillance Systems

- Developing and implementing standardized protocols for death scene investigations
- Increasing the number of follow-back studies of suicides
- Increasing the number of hospitals that code for external cause of injuries
- Increasing the number of nationally representative surveys with questions on suicidal behavior
- Implementing a national violent death reporting system that includes suicide
- Increasing the number of States that produce annual reports on suicide
- Supporting pilot projects to link and analyze information on self-destructive behavior from various, distinct data systems.

The History of the North Dakota Suicide Prevention Coalition. ***Mission and Goals Regarding Prevention of Suicide***. Coalition minutes indicate that the Coalition discussed a vision and mission statement in 2007, although there is no record of their approval. The 2007 Vision was *Resilient individuals in supportive communities*. The mission was *To empower communities to create suicide prevention programs and strengthen resiliency to reduce injury and death*. This vision and mission guided the strategic planning process.

Between 1998 and 2009, the Coalition, with 199 members and 47 organizations (see Table 1.6), held 2 to 7 meetings per year, averaging 3 per year (see Table 1.7). In 1999, the coalition created its first plan, which was distributed in October 2000. In August 2004, the Coalition revised its strategic plan and distributed it in August 2006. Four goals were included:

1. GOAL 1. Dedicate sufficient personnel and fiscal resources to address the issue of statewide suicide prevention activities over a structured and long-term basis.

2. Goal 2. Increase education and public awareness of, and reduce the stigma about, the issue of suicide as a leading cause of death and a significant public health issue in North Dakota for all ages.

3. GOAL 3. Reduce the danger and harm of suicidal behavior.

4. GOAL 4. Promote assets and resiliency to all people, with attention toward building healthy relationships.

Table 1.6. *Organizations Participating in the Coalition 1998-2009*

American Foundation for Suicide Prevention - ND Chapter
Bismarck High School
Bismarck Police Department, Chaplain
Cankdeska Cikana Community College, Wiconi Ohitika Project
City Country Health Department
Community Healthcare
CSN/Suicide Prevention Resource Center
Department of Health, Adolescent Health, EMS, EMSC, Injury/Violence Prevention Program,
Department of Human Services, Mental Health & Substance Abuse, Research Analyst
Department of Public Instruction
DLN Consulting
Episcopal Church - Standing Rock
Fargo Area Clergy

Foster Grandparents Program
Governor's office
Harvey Assembly of God
Indian Affairs Commission
Indian Health Service, Ft. Totten, Ft. Yates, Standing Rock, Mental Health
Interested individuals
Juvenile Services
MedCenter One
Mental Health America of North Dakota
Mercy Hospital - Wellness in the Valley
ND National Guard
ND School Counselors Association
ND State Senate
NDSU Extension
North Dakota Youth Correctional Center (NDYCC)
Northern Lights Youth Service, Inc.
Northwest Human Service Center
Outreach, Inc.
Prairie St. Johns
Region VII CSCRR
SRST Suicide Prevention Program
St. Aloysius Medical Center, Harvey
Standing Rock Health Education, Tribal Health, Oniyapi Program, Suicide Prevention Coordinator
SW Community Action
T.E.A.R.S Org
The Village Family Service
Three Affiliated Tribes, Boys & Girls Club, Tribal Health Administration
Turtle Mountain Band of Chippewa Indians - Papillion Coalition
UND School of Medicine - Center for Rural Health
United Tribes Technical College - Community Health, Injury Prevention Program
VA Medical Center
Volk Human Services
Wellness in the Valley
Youth Ministry

Table 1.7. *Suicide Prevention Coalition Meetings: 1998 to 2009*

Year	Date of Meeting	# of Participants
1998	10/3	5
	12/10	21
1999	1/26	17
	3/9	16
	4/20	18
	6/8	16
	8/9	11
	8/25	8
	10/7	8
2000	3/2	12
	10/24	15
2001	1/23	7
	4/30	9
	7/17	16
	10/24	17
2002	1/30	15
	4/16	10
	10/8	13
	12/3	13
2003	7/15	27
	10/1	21
	11/19	18
2004	1/14	24
	3/17	8
	10/26	14
2005	1/6	18
	4/12	21
	5/24	22
	7/28	12
2006	1/23	9
	8/16	19

2007	6/19	24
	9/27	24
	11/29	31
2008	2/6	29
	5/7	27
	8/6	29
2009	2/4	19
	5/6	24
	8/5	28

In April 2007, the Coalition conducted strategic planning specifically for the Garrett Lee Smith application. At that point, the vision was "Individuals in Supportive Communities;" the mission was "To empower communities to create suicide prevention programs and strengthen resiliency to reduce injury and death." In June 2007, the Coalition determined that bylaws and a formal structure were not needed at that time.

SWOT Analysis. ***Strengths of the Coalition*****.** Following the review of magnitude of suicide, risk factors, other models for strategic planning, and the history of the Coalition in ND, the Coalition completed a SWOT analysis. First, they brainstormed strengths:

- Local Surveillance work. CCCC's BRFSS-like survey on campus provides broad range of data and risk factors. Wiconi Ohitika has MOA with IHS that will help with obtaining data for reporting. YRBS data from local schools used in surveillance document.
- Diversity of coalition membership, i.e. in agencies, target groups, and physical location Direct service providers, instructors, administrative – different levels.
- Partners (i.e. AFSP, MHAND, Human Service Centers, Health Care Providers (IHS, doctors offices, etc.), Universities, Public Schools)
- Many organizations in coalition responsible for suicide prevention
- Coalition's history of suicide prevention since 1998
- Wisdom: Different life experiences to learn from.
- Networking
- People in coalition provide support to prevention providers in the group
- Funding sources (i.e. 4 GLS grants, State funding)
- Longevity and sustainability of individuals of members and organizations – Commitment/dedication
- Local suicide prevention coalitions and their collaboration with other community coalitions such as Safe Communities.
- Cross community partnerships between local coalitions
- Medical, schools, DHS information
- MHAND Behavioral Health Initiative
- Programming (i.e. Children and adolescents, Adults, including older persons)

Gaps in the Coalition. The Coalition then identified gaps:

- Coalition doesn't have independent structure outside NDDoH grant.
- Coalition lacks formal structure.
- Limited authority and connection to the state suicide prevention plan.
- Need plan for the next stage of suicide prevention work.
- Don't have a way to disseminate information through the Coalition.
- Lack of awareness of the Coalition.
- Lack of action plan for Coalition.
- Funding for Coalition operation.
- Lack of long term funding.
- How to staff the Coalition long term.

- Membership: does not have representation from the gay and lesbian community.
- Youth representation inconsistent.
- Survivors and families of victims should also be represented. ND Consumer Family Network is an agency that might be helpful.
- Coalition needs to support suicide prevention efforts and providers more.

Opportunities in the Environment. Environmental opportunities included the opportunity to impact on state policy, related community activities such as the ND Behavioral Health Initiative, statewide support for the Coalition, and national resources such as SAMHSA's anti-stigma campaign.

- Change state policy/Streamline state law for service accessibility.
- ND Behavioral Health Initiative at Three Affiliated Tribes, with educational video and curriculum for rural health providers.
- Create a coalition structure: i.e. Operating board, Foundation to endow the Coalition, Look at 501c3 status – opens up potential for funding, Look at piggybacking with something like AFSP so don't have to start from scratch, Committees to help with public awareness development – work with public awareness provider.
- Projects that are statewide identified with the Coalition – big impact across the state.
- Statewide support for Coalition, Additional state funding.
- Other national funding, public and private.
- Local funding sources.
- National projects with models from which we learn.
- National anti-stigma campaign by SAMHSA.
- Extension Service.
- Add new coalition members, i.e. invite First Link.
- Local prevention coalitions, i.e. Safe Communities people are willing to help on their own time and work time. This is a good model for other coalitions.

Threats in the Environment. Environmental threats ranged from lack of knowledge among health providers, especially in rural areas; state and federal policies that interfere with collaborations between organizations and groups, including jurisdictional issues; multiple layers of screening required for hospitalization; limited access to and delays in receive services; the reluctance of people to participate in services, perhaps due to stigma; and the lack of evidence based strategies.

- Additional knowledge needed by rural medical communities.
- Limited knowledge of suicide prevention in rural communities.
- People don't know about the availability of DHS support/information.
- Limited knowledge of available services in the community.
- State/federal laws that interfere with connections.
- State law can be a barrier.
- Jurisdiction issues, Authority complications between state/tribe.
- Multiple layers of screening – particularly to get to State Hospital (have to be screened by Human Service Centers) Issues with recognition of capabilities of counselors not licensed through the state.
- Access to treatment.
- Too many delays can prevent treatment because consumer willingness changes.
- Loss of 2-1-1 from MHAND as of 10-20-09…not enough $$$ to support it and it has been relinquished back to PSC.
- Reluctance of individuals to participate in formal services.
- Economy

- Lack of stable funding for prevention.
- War
- Lack of evidence based prevention programs nationally.
- Cost of addressing risk factors.
- Other prevention projects addressing similar populations.

Development of Coalition Goal and Objectives. ***November 2009 Coalition Meeting.*** Draft goals and objectives emerged from the initial SWOT analysis and brainstorming November 2009. Coalition members' responses to the initial goals and objectives (see Table 1.8).

Table 1.8. *Goals and Objectives following November Strategic Planning Session*

Goals	Objectives and Strategies
Establish operating structure, such as 501c3 or partner with another organization that already has private nonprofit status	Active board
	Successful leadership model
	Productive subcommittees, for example: • Public awareness/ Public relations • Planning/participating in events • Sustainability: Funding and sponsorship • Data • Lobbying to change public policy at various levels of government
	Increase awareness of the coalition throughout the state. Handout materials to show potential supporters/volunteers what we're about & how they can be involved – help them see the connection to themselves
	Communication plan
Maintain diverse and active coalition membership	youth
	GLBT
	'movers & shakers'
Suicide prevention activities across the life span	Target highest risk group (young adults)
	Increase awareness and availability of resources throughout the state, including Identifying resources for off-reservation American Indians
	Support 2-1-1 as a statewide resources
	Support prevention strategies such as Sources of Strength
	Media plan
	Coalition be formally a part of 'Out of the Darkness' walks, other state events, etc.
	Send Coalition members to represent us at conferences, etc.
Decrease stigma surrounding discussion of suicide issues. Transforming public attitudes through awareness & dialogue – stigma	

Coalition members were invited to respond to a Survey Monkey survey rating the importance they placed on these goals and objectives. All goals and Objectives were rated highly by Coalition members (see Table 1.9). The highest rated goals and objectives were:

Objective 6 of Draft Goal 1. When the ND State Suicide Prevention Plan is revised, ensure that the ND Suicide Coalition is included in the plan.
Draft Goal 2. Maintain diverse and active coalition membership.
Draft Goal 3. Focus on suicide prevention across the life span.

> Objective 1 of Draft Goal 3. Develop a PLAN for supporting suicide prevention across the life cycle.
> Objective 2 of Draft Goal 3. Identify and target HIGH RISK groups, such as young adult.
> Draft Goal 4. Decrease stigma surrounding discussion of suicide issues. Transforming public attitudes through awareness & dialogue – stigma

No one suggested any new goals or objectives. One person worried about the impact of Senator Dorgan's resignation on projects in North Dakota. Another suggested a general need for more focus on rural health and prevention. A final comment highlighted the importance of suicide prevention:

> I am very impressed with these objectives and goals. I do feel it is most important to get suicide prevention, especially through the coalition, into the media.

Table 1.9. *Coalition Members' Ratings of Draft Goals and Objectives Following the November Coalition Meeting*

Draft Goals and Objectives	Mean	SD	Miss-ing	Suggestions
Draft Goal 1. Establish operating structure, such as 501c3 or partner with another organization that already has private nonprofit status.	4.24	.831	0	• My suggestion is to partner with the American Federation of Suicide Prevention or with Mental Health America of ND. • formal operating structure in place by 2011 • Essential for policy making and lobbying.
Objective 1 of Draft Goal 1. Active board	4.53	.943	0	• High level of participation by Coalition Board members in meetings and workgroups • Board needs to be engaged with all aspects of the Coalition.
Objective 2 of Draft Goal 1. Successful leadership model	4.65	.786	0	• Formal operating structure articulated in by-laws (or similar structure) with leadership roles defined. • Will need to describe what this will look like and how to achieve this.
Objective 3 of Draft Goal 1. Productive subcommittees, for example: Public awareness/ Public relations, Planning/participating in events, Sustainability: Funding and sponsorship, Data, Lobbying to change public policy at various levels of government	4.65	.606	0	• Subcommittees (number, responsibilities) articulated in formal structure. Subcommittees achieve their objectives in their workplans. • I hate the word subcommittee. It infers less important. Why not just call them committees?
Objective 4 of Draft Goal 1. Increase awareness of the coalition throughout the state. Handout materials to show potential supporters/volunteers what we're about & how they can be involved – help them see the connection to themselves	4.53	.717	0	• Handouts are okay but they sometimes can be a waste of paper. If there was a way to tie into modern technology such as email, facebook etc. A small printed piece directing people to websites and other tech sources for info. • Work marketing plan through designated partnering 501(c)3. • communities need to be informed as to who we are and what we do • ND Suicide Prevention Coalition respected throughout the state. • The first step to prevention is education and awareness. • Important to support tribal and non-tribal awareness and support
Objective 5 of Draft Goal 1. Communication plan	4.63	.619	1	• Unsure what this means • Very valuable - follow up is critical • Having off site tele-prompt is excellent improvement
Objective 6 of Draft Goal 1. When the ND State Suicide Prevention Plan is revised, ensure that the ND Suicide Coalition is included in the plan.	4.88	.485	0	• I believe that the ND Suicide Coalition could be a stronger force in our state. • ND Suicide Prevention Plan revised by 2011, including an active Coalition as one Goal.

Draft Goal 2. Maintain diverse and active coalition membership	4.80	.414	2	• Membership of Coalition represents the population of the state, with special attention to representation by high risk groups, people with the ability to create change, ...? • Diversity adds inclusiveness.
Objective 1 of Draft Goal 2. Increase the presence of youth in the Coalition.	4.33	.816	2	• Utilize college age as there may be more flexibility with scheduling and ownership • I believe the youth input is very important • People of all ages represented in the Coalition. • Their ideas are tantamount to getting the right message across.
Objective 2 of Draft Goal 2. Increase Lesbian, Gay, Bisexual, Transgender, Queer, Intersex (LGBTQI) involvement in Coalition.	4.07	.829	3	• What is GBLT? • Diverse groups represented in the Coalition. • Missing a letter or two I think Questioning/Queer is missing as well as Intersex.
Objective 3 of Draft Goal 2. Increase the participation of 'Movers & shakers' in the Coalition.	4.27	.884	2	• Might we want to consider describing particpants as knowledgeable and committed, willing to put in the time needed • People with the ability to create change represented in the Coalition.
Draft Goal 3. Focus on suicide prevention across the life span	4.75	.447	1	• Youth suicide is important. Statistics show that, overall, completions are more likely to be done by older individuals. We need to address suicide in middle and older age people. • suicide is not just with the youth anymore • given the needs and data, we need to broaden our focus. • The ND Coalition will create and implement a plan for suicide prevention. • This will have many components. Important to start with a few initiatives and get them done then move on to the rest.
Objective 1 of Draft Goal 3. Develop a PLAN for supporting suicide prevention across the life cycle	4.75	.447	1	• The Suicide Prevention Plan will be revised for 2010-2015, based on current data.
Objective 2 of Draft Goal 3. Identify and target HIGH RISK groups, such as young adult	4.81	.403	1	• And older adults • Current surveillance information will be used to create the plan, and made available annually for ongoing planning. • Focusing on high risk populations as related to our state is extremely important. • develop initiatives for employee awareness and warning sign reporting tool. how can employees help
Objective 3 of Draft Goal 3. Increase awareness and availability of RESOURCES throughout the state, including identifying resources for off-reservation American Indians	4.63	.619	1	• We have families in urban areas throughout ND and need to know what the resources are. • Ensure that the 211 (or other 24-7 resource) is up to date and available throughout the state.
Objective 4 of Draft Goal 3. Support 2-1-1 as a statewide resource	4.47	.743	2	• People need to know where to go for help. • This is a great resource for all communities in ND • Are we talking financial support? Is there another opportunity for crisis lines to consider? For example, the human service centers all have after hours numbers • We need more information about the transfer of 2-1-1 to First Link to understand if there are any changes in the future.
Objective 5 of Draft Goal 3. Support effective prevention strategies across the life cycle.	4.56	1.031	1	• Utilizing existing resources such as Sources of Strength. • grief and depression in the elderly and all age groups • Identify evidence-based strategies for primary prevention of risk factors for suicide.
Objective 6 of Draft Goal 3. Media plan	4.44	.727	1	• How we deliver our message regarding suicide, so that we do not get negative feedback, such as glamorizing, glorifying, suicide.
Objective 7 of Draft Goal 3. Coalition be formally a part of 'Out of the Darkness' walks, other state events, etc.	4.47	.743	2	• I feel that this helps the families, communities that have losses to suicide health • Critical for visibility, involvement, commitment, would really help bring together all efforts

Objective 8 of Draft Goal 3. Send Coalition members to represent us at conferences, etc.	4.00	.966	1	• ND Suicide Prevention Coalition a partner in national, state, regional, and local prevention activities • Budget concerns here.
Draft Goal 4. Decrease stigma surrounding discussion of suicide issues. Transforming public attitudes through awareness & dialogue – stigma	4.81	.544	1	• Big job and will take all of us together. • I see this as a systems issue in ND that the coalition along with American Foundation for Suicide Prevention-ND, human services, Mental Health Association in North Dakota, etc need to do together • This might be part of Goal 3? an objective or a strategy under prevention of risk factors? • Stigma is probably the biggest issue related to suicide and in particular for survivors of suicide loss.

At the February 2010 Coalition meeting the members reviewed goals and objectives and feedback from the survey, refined goals, developed standards for objectives and provided feedback on the draft objectives, and developed plan for final tweaking of goals and objectives and development of strategies:

a. Creation of a working group for each goal,
b. Assigning a leader for each group,
c. Schedule of workgroup meetings, and
d. Present reports at May Coalition meeting.

Coalition members reviewed and tweaked the four goals identified in November meeting; the four goals were combined into two goals/categories: 1) Establish Coalition infrastructure, and 2) what the Coalition would do/Suicide Prevention Activities. The timeline for goals was set as 5 years with annual reevaluations. The Coalition members worked in two groups over the next three months, refining the two goals, developing objectives, and identifying strategies, activities, and the timeframe (see Table 1.10).

Table 1.10. *Ideas generated during Coalition Meeting regarding Goals*

Goal 1. Establish a sustainable operating structure for the ND Suicide Prevention Coalition. Obj1.1: Whether want to be 501c3 or join with existing organization. Pros of 501c3: ability of stand alone group, to testify. Cons of 501c3: complicated procedure Activities: 1) find out/clarify Public agencies' relationship coalition 2) Determine process for becoming 501c3 Obj1.2: develop resources for coalition (use model of governor's council on mental health) Activity: 1) identify source of funding for coalition work (meetings, travel) Obj 3. Determine possibility of being council.
Goal 2. What the coalition will do. Focus on suicide prevention across the life span? Coalition focused on adolescent suicide. Want to expand to older adults, also. Add decreasing stigma to this goal.

Details for each goal were brainstormed in small group meetings in the afternoon:

Goal 1 Establish a sustainable operating structure for the ND Suicide Prevention Coalition

1. Infrastructure group
    a. Steering committee membership
        i. include chairs of committees, officers, add 4 at large members to ensure representation.
        ii. Dept of health voting member of steering committee
        iii. Representation by profession, ie. Law enforcement.
        iv. No more than 1 person per agency on a steering committee.

b. Officers of Coalition (also lead steering committee): Rotation of officers annually, chair, co chair, secretary in year 1, year 2 elect cochair (cochair from year 1 is now chair), past chair remain on the steering committee also. Draft of roles by August.
c. Subcommittees. Draft of roles by August. What standing Committees recommend? Advocacy, public awareness/ed, diversity and recruitment, Suicide Prevention Plan
d. Coalition Membership. Active members pay membership fee. Inactive or informational members. Can't be active right now but want to stay in touch. Membership recruitment; update membership list. Draft of roles by August. MHAND will handle memberships.

FEES: agency: $100. Each agency gets one vote on the Coalition and will designate one person to represent the organization on the Coalition. If an individual chooses to join, they also have a vote regardless of where they worked. Individual/professional $25. Community members at $10

2. Prevention Programming: Endorse evidence based practices. Identify evidence-based practices for:
   a. gate keeping,
   b. screening (vision, mental health), (Ex of tools: diagnostic and predictability scales out of Columbia, Prairie St. John work w schools in the Eastern part of the state; Innovis has screening program Shawna Croaker, Children's Mental Health Initiative, Dakota Medical Foundation)
   c. crisis responding,
   d. primary prevention across the life span (early childhood, primary education, secondary education, young adult, middle adult, old age).
   e. Diversity, how ensure that all materials are appropriate for the group involved, i.e. in screening, families, interventions. Ex of great diversity, Fargo Community Health Clinics. Rural communities and access to health care.
   f. Work site wellness. Injury prevention, including mental health wellness and suicide prevention. Partner with Blue Cross and Blue Shield. Summit in September.
3. Incorporate mental health and suicide prevention into health care and teacher professional training.
4. Continuing Education, partner with AHEC
5. Sustainability—how work together, understand each other better, to coordinate so collaborate, not compete, for resources. Align with partners who can support sustainability, i.e. Dakota Medical Foundation. North Dakota AHEC.
6. Resources, issues re access to health care in rural communities. Work across geographic areas to share resources. Diversity across communities.
7. Create Coalition Committee re: sustainability for prevention programming.
8. Data, ND DOH advocate for hospital discharge data. Payment data. Create method of identify need, i.e. story of adolescent transported to state hospital with cuffs.
9. Identify gaps and areas for advocacy, i.e. improving access to care through the creation of a Mental health transportation system in ND rather than law enforcement. Dignified transportation. Training for transporters. Faith in Action resource.
10. Process for work on Goal 2: In the Short term, add all these brainstorming ideas into the existing workplan. The workgroup will meet 2 times this summer, the first time May 24 to create common language in goals and objectives. By August, the workplan will be cleaned up, dates added, and additional stakeholders identified. Beth and Katie will continue as co-chairs; other members may send them e-mails re ideas. This committee's recommendation to the other work group is that they create a process where by each committee makes recommendations to the Coalition for approval. Each committee chair will sit on the Steering Committee.

Strategies and Objectives for the Plan. The two workgroups agreed to meet prior to the August Coalition meeting to develop strategies/activities and a timeframe, using a workplan offered by Mary Weiler to standardize reporting back to the Coalition:

Workgroup 1, Goal 1: sustainable operating structure. Susan H. and Mary W will be co-leaders. Gail Erickson will staff the committee. As much as possible, get equal representation on the workgroup, Paula, Arlis, Mark L., Clayton. Gail staff this group/manage e-mails, set

up meetings, notes. Use electronic methods for meetings, i.e. Speaker phone/conference calls, e-mails, and video system, also.

Workgroup 2, Goal 2. What the coalition will do. Katie and Beth co-lead. Diana, Stephanie, Deb, The media plan part of this. Pat staff.

Goal 2 Workgroup met May 24, identifying resources (see Table 1.11), creating a workplan (see Table 1.12), and identifying additional issues to be addressed later.

Table 1.11. *Resources*

Substance Abuse and Suicide Prevention: Evidence Implications: A White Paper	www.samhsa.gov/matrix2/508**suicideprevention**paperfinal.pdf
AFSP Resources	http://www.afsp.org/index.cfm?fuseaction=home.viewPage&page_id=7429D2BB-E872-022D-4C30270097885002
SPRC Resources	http://www.sprc.org/featured_resources/index.asp
NIMH	http://www.nimh.nih.gov/index.shtml
Zero to Three	http://www.zerotothree.org/site/PageServer?pagename=prof_professionals
Healthy Families	http://www.healthyfamiliesamerica.org/home/index.shtml
JAMA article on aging and suicide	http://jama.ama-assn.org/cgi/reprint/291/9/1158.pdf

They identified issues to be addressed later:

1) How to get info out to more stakeholders. Use naturally occurring opportunities for training. Ie media students. Law enforcement and other first responders (police, paramedics).

2) Conduct a resource and needs assessment survey of Coalition membership in July/August to inform strategic planning. Add to needs asst re funding needs. Transportation, include in needs asst to assist with id gaps.

3) Prevention Programming: Endorse evidence based practices. Identify evidence-based practices for:
   a. gate keeping,
   b. screening (vision, mental health), (Ex of tools: diagnostic and predictability scales out of Columbia, Prairie St. John work w schools in the Eastern part of the state; Innovis has screening program Shawna Croaker, Children's Mental Health Initiative, Dakota Medical Foundation)
   c. crisis responding,
   d. primary prevention across the life span (early childhood, primary education, secondary education, young adult, middle adult, old age).
   e. Diversity, how ensure that all materials are appropriate for the group involved, i.e. in screening, families, interventions. Ex of great diversity, Fargo Community Health Clinics. Rural communities and access to health care.

   f. Work site wellness. Injury prevention, including mental health wellness and suicide prevention. Partner with Blue Cross and Blue Shield. Summit in September.

3) Incorporate mental health and suicide prevention into health care and teacher professional training.
4) Continuing Education, partner with AHEC
5) Sustainability—how work together, understand each other better, to coordinate so collaborate, not compete, for resources. Align with partners who can support sustainability, i.e. Dakota Medical Foundation. North Dakota AHEC.
6) Resources, issues re access to health care in rural communities. Work across geographic areas to share resources. Diversity across communities.
7) Create Coalition Committee re: sustainability for prevention programming.
8) Data, ND DOH advocate for hospital discharge data. Payment data. Create method of identify need, i.e. story of adolescent transported to state hospital with cuffs.
9) Identify gaps and areas for advocacy, i.e. improving access to care through the creation of a Mental health transportation system in ND rather than law enforcement. Dignified transportation. Training for transporters. Faith in Action resource.

A second meeting to refine the workplan after representatives of the two groups met, scheduled July 12, 2010, 3-4 PM, was cancelled because Group 1 had been unable to meet.

Table1.12. *Goal 2 Recommendations*

Goal 2. Prevent suicide through reduction in risk factors correlated with suicide and early identification.	Objectives	Activities	Sub activities	Timeframe for accomplishing activities	Resources, Partners, Personnel, Support, Equipment	Ideas regarding Strategies and Resources to assist with planning	Notes
	1. Decrease stigma associated with mental disorders.	Create a formal plan for reducing stigma.		july			
		Conduct needs assessment: Find out what anti stigma activities are currently available in the state and national resources.	Use same data from 2001 plan		http://www.adcouncil.org/newsDetail.aspx?id=331	Might be missing representation from far se and far sw Use local public health directors/really helpful in those community	
			Survey members, what going on in community re suicide prevention. Also questions about needs: get list of members, what regions not covered?	july			
			Write draft report and disseminate	Aug meeting			
			Use information to revise ND Suicide Prevention Plan				
		Use standardized curricula, such as QPR, throughout the state.				http://www.qprinstitute.com/	
		Conduct a media campaign, How we deliver our message regarding suicide, so that we do not get negative feedback, such as glamorizing, glorifying, suicide.				Guide to Engaging the Media http://www.spanusa.org/files/General_Documents//media.pdf	
		Support member organizations	Participate in "Out of the Darkness" walks which support AFSP through funding and visibility		AFSP	Info and 2010 Participation packet: http://www.outofthedarkness.org/ Walks scheduled in ND 2010: http://afsp.donordrive.com/index.cfm?fuseaction=donorDrive.eventList&eventGroupID=9AA117B3-F522-BB6D-359D1AA2D75A7958&filter=true&state=North Dakota	

		Incorporate mental health and suicide information into health and mental health education programs, emergency responder training, ministers, and teacher professional training.				Free Teen Screen Primary Care for health care professionals: • Pediatric Symptom Checklist for Youth(PSC-Y)- mental health screening questionnaire covering depression, anxiety, attention, conduct and suicidality http://www.teenscreen.org/images/stories/PDF/psc-y%20read%20only.pdf • Patient Health Questionaire Modified for Teens (PHQ-9)- depression screening questionarire http://www.teenscreen.org/images/stories/PDF/phq-9%20read%20only.pdf http://www.jasonfoundation.com/	
	2. Increase gatekeeping and crisis response	Identify and endorse evidence-based programs for gate-keeping, screening, and crisis response.			QPR, teen screen, Lifeline resource Are going to move people to using more evidence based, if yes, how. Schools—has to be evidence based.	QPR training online, click on "Learn QPR right now" http://www.qprinstitute.com/	
	3. Increase primary prevention programming across the life span, considering diversity.	Identify and endorse evidence-based strategies for primary prevention of risk factors for suicide.	Use data from needs asst to examine how to change to more evidence based strategies Determine what level of involvement, from				Life Skills Training for Adolescents American-Indian Skills Development Curriculum http://www.amazon.com/American-Indian-Skills-Development-Curricul

			identify to support to implement Risk factors for suicide, J. will send. Add to needs assessment?				um/dp/0299149242, *and then by clicking on "Look Inside!"* CARE (Care, Assess, Respond, Empower) [Formerly called Counselors CARE and Measure of Adolescent Potential for Suicide] http://www.reconnectingyouth.com/programs.html (CARE link coming soon) CAST (Coping and Support Training) http://www.reconnectingyouth.com/cast PROSPECT (Prevention of Suicide in Primary Care Elderly: Collaborative Trial) http://www.nrepp.samhsa.gov/programfulldetails.asp?PROGRAM_ID=113#description US Air Force Suicide Prevention Program http://afspp.afms.mil/idc/groups/public/documents/webcontent/knowledgejunction.hcst?functionalarea=AFSuicidePreventionPrgm&doctype=subpage&docname=CTB_018094&incbanner=0 Emergency Room Intervention for Adolescent Females http://chipts.ucla.edu/interventions/manuals/interer.html Signs of Suicide http://www.sprc.org/featured_resources/bpr/ebpp_PDF/sos.pdf http://www.mentalhealthscreening.org/schools/index.aspx Columbia University TeenScreen Program http://www.teenscreen.org/
		Develop initiatives for employee awareness and warning sign reporting tool.	Identify partners through needs assessment (start with BCBS, find ways to look at that wellness model.) Develop direction, gatekeeping or self help.		BCBS wellness Beth will contact BCBS (Diana send her the contact info) to see what is reasonable.	https://www.bcbsnd.com/employers/wellness/	
		Grief across the life cycle	Develop as develop plan Centralize information regarding this.		Survivors of Suicide	Link to resources for support groups, websites, etc. http://www.survivorsofsuicide.com/resource_links.shtml	
		Depression, across the life cycle, different groups (gender, race, income, etc.)		Put in needs asst. Dakota med foundation partner w grant from rwj hand held devices in pediatrician office, m/h concerns. Do we have easy to use screening tools.	What is SAMHSA doing re: screening for depression? Treatment?	Mental Health and Substance Abuse Resources SAMHSA http://www.samhsa.gov/treatment/index.aspx More resources addressing diversity http://www.afsp.org/index.cfm?fuseaction=home.viewPage&page_id=7429AB1E-EF88-4847-6DC010CBA738604C	
		Updated list of resources statewide					
		Dissemination of sources for finding resources, i.e. 211, suicide lifeline, firstlink					
		Incorporate mental health and suicide					

		primary prevention information into health care and teacher professional training.					
		Identify partners.	Attorney general spokesperson for Jason Foundation Other partners? i.e. educational institution representatives ND Emergency room physicians association, innovess er Karen Larsen community health centers Northland, wellness project		AHEC?		
	4. Increase sustainability of prevention programs.	Create committee to find funding for prevention programming.					Are these appropriate for a separate goal? Need to do needs asst first, bring together partners, then work on this.
		Work with the legislature to maintain funding for prevention programming.					
		Coordinate Coalition members; activities across the state, sharing resources with each other.					
	4. Maintain current information regarding suicide behaviors and risk factors.	Complete and distribute annual surveillance report, using data from the YRBS, BRFSS, Coroner's office, etc.					Potential new coalition partners: call kathy Moum to find out who contact at Coroner's office
		Support already existing sources of data, such as the Coroner's office, the YRBS and the BRFSS.			YRBS—DPI BRFSS—DoH, Melissa Parsons		
		Develop new sources of data, such as the National Violent Death Reporting System			NVPN contact: Paul Bonta 202-466-2044	Surveillance for Violent Deaths- includes what data is collected as well as definitions of manner of death http://www.cdc.gov/mmwr/preview/mmwrhtml/ss5703a1.htm Homepage detailing funded and	http://www.cdc.gov/ViolencePrevention/NVDRS/faqs.html glean information from this.

						participating states http://www.preventviolence.net/	
		Develop method for identifying gaps and areas for advocacy, i.e. the need for dignified transportation of persons with mental illness					

Establishment of Infrastructure at August 2010 Coalition Meeting. At the August 2010 Coalition meeting, the members established the initial infrastructure:

- Agreed to make decisions by simple majority.
- Approved four offices and elected officers:
  Chair: Beth Huseth
  Chair-elect: Mary Weiler
  Secretary: Antonette Halsey
  Treasurer: Susan Helgeland
- Mental Health America will be the fiscal agenda.
- Created Executive Committee, including the officers.
- Created Steering Committee, including officers and lead person for each workgroup. More members will be added later.
- Established five workgroups:
  1. Advocacy and Public Policy: Susan Helgeland, Dawn Hoffner, James Pfiefer (representative on the steering committee). (Potential members, State Hospital, Lutheran Soc. Services, Hospital, UND School of Medicine, legislators) from Republican and Democratic parties.)
  2. Prevention Strategies: Cora Whiteman, Stacie Loegering, Clayton Nelson, Melissa Walters, Dawn Hoffner, Beth Simon, Mark LoMurray, Robert Chase Hischase, Sr., Wendy Yankton (representative on steering committee), Pat Conway, James Pfeifer, LaVonne Fuchs, and Arlis Littlewind. Potential representation, DHS, DOH, schools, ministry, National Guard, NDUS, EMT, police, emergency doctor and ND Counselor's Association). Suggested having a list of "who does what" in activities and who a person can contact when needed.
  3. Diversity and Membership: Gail Erickson (representative on steering committee), Toni Halsey and Mary Dasovick. The membership list needs to be updated. Send out to everyone via e-mail and then Vicky can make phone calls to see who is staying on the membership list Gail Erickson will temporarily be on Steering Committee.
  4. Data and Evaluation with John Haugen and Pat Conway (representative on steering committee).
  5. Funding and Sustainability – no members yet.

The Executive Committee was charged with meeting prior to the November Coalition meeting to prepare for the next steps, making recommendations regarding issues such as membership requirements and to identify next steps regarding infrastructure development.